The spirit of the Knowledge Society…a readiness to accept the Other, indeed to learn from him, to see difference as an opportunity rather than a threat. Such a spirit must be rooted, I believe, in a sense of humility before the Divine, realizing that none of us have all the answers, and respecting the broad variety of God's creation and the diversity of the Human Family. (Prince Karim Aga Khan, 19th convocation, December 2, 2006, AKU, Karachi, Pakistan)

University of Alberta

# Competence of Graduates of the Four-Year BScN Program at Aga Khan University: Experiences and Perceptions

by

Raisa Begum Gul ©

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in partial fulfillment of the
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# Abstract

Although extensive information is available in the literature about the competence of graduates from four-year Bachelor of Science in Nursing (BScN) programs in developed countries, little is known about the outcomes of such programs in developing countries. This study was undertaken in the context of a developing country - Pakistan.

The goal of my study was to explore and understand how nurses from a four-year BScN program at Aga Khan University School of Nursing (AKU-SON) view their competence based on their personal experience and how their competence is viewed by others, specifically by their supervisor in the nursing workforce at Aga Khan University. For the purpose of this study competence was conceptualized in a holistic sense; that is, inclusive of knowledge, skills, attitudes, and performance. A focused ethnography approach was employed in this study. The data was collected between March- June, 2006, through semistructured interviews with 24 informants, participant observation in the nursing services, and a review of institutional documents pertinent to the phenomenon of this study.

To identify explicit and implicit patterns of perceived competence among the BScN graduates, data was content analyzed. Results indicate multiple strengths of the graduates in accordance with program goals, but identify some curriculum gaps as well issues of the work environment that must be addressed to actualize the full potential of the graduates. Findings of this study will offer strategic guidance with regard to future planning for pre-licensure educational programs and curriculum development at AKU-SON. In addition, information acquired through this study will be useful for the nurse leaders and policy makers in Pakistan and other countries in the region who share similar

socio-cultural and economic challenges with Pakistan. Finally, this study has generated baseline information for future research that will contribute in the development of professional nursing education in Pakistan.

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## List of Acronyms

| | |
|---|---|
| AKHSP | Aga Khan Health Services, Pakistan |
| AKU | Aga Khan University |
| AKU-CHS | Aga Khan University Community Health Sciences |
| AKUH | Aga Khan University Hospital |
| AKUMC | Aga Khan University Medical College |
| AKU-SON | Aga Khan University School of Nursing |
| BHU | Basic Health Unit |
| BScN | Bachelor of Science in Nursing |
| CNI/CNT | Clinical Nurse Instructor/Clinical Nurses Teacher |
| DTA | Diploma in Teaching Administration |
| DWA | Diploma in Ward Administration |
| ERC-AKU | Ethical Review Committee, Aga Khan University |
| HN | Head Nurse |
| HREB-U of A | Health Research Ethics Board, University of Alberta |
| LHV | Lady Health Visitor |
| LHW | Lady Health Workers |
| NES | Nursing Education Services |
| RM | Registered Midwife |
| RN | Registered Nurse |
| PNC | Pakistan Nursing Council |
| TL | Team Leader |
| WHO | World Health Organization |

# CHAPTER ONE:
# INTRODUCTION

This dissertation is an exploratory study about the competence of four-year Bachelor of Science in Nursing (BScN) graduates at Aga Khan University (AKU), Pakistan, based on the experiences and perceptions of the graduates and their supervisors in the nursing workforce. It is divided into seven chapters. Chapter One begins with the importance of baccalaureate-degree education in nursing, highlights its associated challenges at a global level, and provides a background for the study. In addition, Chapter One contains the purpose, questions, significance, and context of the study. Chapter Two presents the literature review pertinent to the study. Chapter Three details the study method—that is, focused ethnography and its implementation. Chapter Four provides characteristics of all BScN nurses who graduated from Aga Khan University School of Nursing (AKU-SON) between 2001 and 2005 as well as the sample demographics, and a brief description of the units where I conducted my participant observation. Chapters Five and Six present the analysis of the data from graduates and supervisors. Finally, Chapter Seven consists of discussion of the data. In addition, it includes recommendations, strengths and limitations.

The rapidly occurring changes in health care delivery have affected nursing practice, employment, and education. The evolving healthcare practice arena demands that nursing education prepares nurses who are capable of providing safe and competent care in uncertain, rapidly changing, and complex situations. Similarly, these nurses should be able to manage the extensive workload of patient care with efficiency and have the ability to work in interdisciplinary healthcare teams effectively. Thus, besides factual knowledge and psychomotor skills, nurses must be able to think critically, make effective clinical judgments and decisions relevant to patient care, problem-solve, demonstrate leadership, stay abreast of information technology, and be lifelong learners (Halstead, Rains, Boland, & May, 1996; Manuel & Sorensen, 1995; Martin, 2002; May, Edell, Butell, Doughty, & Langford, 1999; Maynard, 1991; Nichols & Chitty, 2005; Pearson, 2002; Utley-Smith, 2004).

In view of the above demands on nurses, there is a growing trend within the nursing profession, particularly in developed countries, to require a Bachelor of Science in Nursing or Baccalaureate in Nursing (BScN or BN) as the minimum entry requirement for professional practice. Considering the positive effects of baccalaureate education in developed countries, some developing countries, including Pakistan, intend to move in that direction. Consequently, AKU-SON in Pakistan initiated a four-year BScN program in 1997. However, the impact of this program in regards to its graduates' competence in the nursing workforce required exploration.

Although there is increasing evidence to support the fact that the level of nursing education has an impact on the clinical competence of nurses (Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Ashworth, Gerrish, Hargreaves, & McManus, 1999; Bartlett, Simonite, Westcott, & Taylor, 2000; Girot, 2000b; Johnson, 1988; Nichols & Chitty, 2005; Ryan & Hodson, 1992; Schwirian, 1978), the importance of baccalaureate prepared nurses as an entry-to-practice qualification is still being debated by some (Beach, 2002; Greenwood, 2000; Joyce-Nagata, Reeb, & Burch, 1989; McCloskey & McCain, 1988; Watson, 2002). As a result, there is no uniform standard of professional education in nursing (Doran, Sidani, Keatings, & Doidge, 2002; Gould, 1999; Millar, 1980; Nichols & Chitty, 2005). Variations exist between as well as within a country. For example, some provinces in Canada (Ross-Kerr, 1999) and three of the four countries in the United Kingdom (Clinton, Murrells, & Robinson, 2005) continue to accept a diploma, or baccalaureate degree as the professional education for obtaining registered nurse (RN) licensure. One may obtain RN licensure after an associate degree (AD), diploma, or baccalaureate degree in the United States (Nichols & Chitty, 2005) and Saudi Arabia (Abu-Zinadah, S, personal communication, November 23, 2005). Each of these programs in these jurisdictions is still considered able to provide the necessary preparation for practice as a professional nurse and is approved by their corresponding nursing regulatory body.

Among others, the American and Canadian Nurses Associations endorsed the baccalaureate degree as the minimum qualification for entry to practice in 1965 and 1982 respectively. The preparatory phase for Baccalaureate education in North America began in early 20th Century. In the USA the first BScN program was established in 1909 at the University of Minnesota and in Canada in 1919 at the University of British Columbia. Various reports of the early 1900s (Committee for the Study of Nursing Education, 1923;

Weir, 1932) indicate that nurse leaders were suggesting that professional nursing education be placed in colleges and degree granting institutions and hospital based apprenticeship training be abolished. This was considered important for the professional education of nurses. Following the above mentioned reports, gradually, over a period of four to five decades, nursing education was moved to colleges and universities with an increasing number of degree nurses in Canada and the USA (Nichols & Chitty, 2005; Ross-Kerr, 1999).

The move towards all baccalaureate education in nursing has been slow because of various sociopolitical factors within and outside nursing including the influence of medicine (Kinnear, 1994). Nichols and Chitty (2005) asserted that the change from a diploma to a BScN program not only involves changes in the duration and subjects of the program, but also requires a complete theoretical and philosophical shift in the delivery of the nursing curriculum because the theoretical and scientific orientation of a university-based BScN program "was in marked contrast to the 'hands on' skill and service orientation" (p. 37) of hospital-based diploma education. The change from hospital-based to university-based education also involves a shift of power among the stakeholders in nursing education, especially nurse educators and employers.

The move toward baccalaureate degree education for entry into practice has been one of the most contentious issues in nursing and has serious implications (Girot, 2000a; Gosnell, 2002; Ross-Kerr, 1999). Rabetoy (2002) feared that if nursing is unable to resolve this issue, then time will resolve it with some undesirable consequences. The author asserted that the brightest and most promising young students will be attracted by disciplines other than nursing to seek true professional and career opportunities. Others may "leave the profession to seek opportunities where they can have an undisputed identity. Finally, nursing will be appropriately classified as a humanitarian and technical vocational group" (¶ 6). Cathcart (2003) pointed out that, whereas other health care disciplines are aspiring towards a clinical doctorate as entry-level preparation, nursing is still debating undergraduate-degree preparation. Concurrent with these views, Buller and Butterworth (2001) suggested that "nursing is in a state of perpetual crisis" because of its identity, which is frequently demonstrated in its debates "about skill, competence, levels of practice, and organisation of training" (p. 414). As a profession, nursing has yet to define what is expected of nurses (Beach, 2002; Miller, 1980).

Girot (2000a) contended that there is a lack of clarity on whether the profession of nursing is aspiring to one level of competence with two different academic awards or two different levels of competence because the RN licensure exam, such as the NCLEX in the USA, tests for the same content regardless of the graduates' prelicensure educational preparation. Cathcart (2003) argued that the licensure examination is concerned with the minimum level of professional competence at the entry level rather than an expert level of practice. Hence, it focuses on the job-related knowledge, skills, and abilities needed for safe and effective practice instead of measuring "the broad scope of health care system's requirements for nursing care" (p. 121). Cathcart asserted that the RN licensure examination is not the right remedy to resolve the dispute over entry-to-practice qualifications.

In Cathcart's (2003) view, nursing leadership must have the courage to make bold decisions and resolve the issue of entry-to-practice qualifications if nursing aspires to be at par with other professions in the society. However, it is important to note that the role and status of nurses in society are influenced by multiple factors besides educational preparation. For example, AbuGharbieh and Suliman (1992) stated that nurses in Jordan are educated to work as change agents, patients' advocates, health educators, and critical thinkers. However, in practice they are required to work "more like medical assistants and house keepers. Thus nursing is considered a menial work" (p. 149). Hence, a dissonance between nurses' education and their roles in practice is apparent. Changing patterns of education may not affect the status of a profession unless a change in the professional role is desired by the society, negotiated among its stakeholders, and supported through structural changes to facilitate the graduates in actualizing their potential.

Embedded in their unique philosophies, nurse educators and employers have differing expectations of graduates' abilities. Unlike in the past, when hospital-sponsored nursing education programs were geared to focus on psychomotor skills, today the baccalaureate programs controlled by educators emphasize a broader range of cognitive and affective skills, which may become a source of tension between them (Sweeney, Regan, O'Malley, & Hedstrom, 1980; Ryan & Hodson, 1992). Greenwood (2000) echoed these views and elaborated that nurses in services complain that the BScN nurses are inadequately prepared for service provision at the time of graduation because they have insufficient clinical and patient-management skills. Yet, many schools of nursing have more clinical hours in their curriculum for the BScN than for the diploma program. Nurses in education "claim to prepare 'beginning' rather than competent practitioners, who are critically reflective and committed to lifelong learning. They also believe that service colleagues could do more to ease the transition experiences of new RNs" (p. 17). However, to facilitate the smooth transition of graduates from the school subculture to the real world, the differences in perspectives must be addressed and negotiated. Educators must determine the needs and requirements of the service sector in delivering nursing care and translate them into suggestions for revisions of the curriculum and further educational planning (Manuel & Sorensen, 1995; Millar, 1980; Ryan & Hodson; Tzeng & Ketefian, 2003).

Because the BScN curriculum differs from other kinds of prelicensure education, some nurse scholars have maintained that BScN nurses are different in kind from diploma or associate degree nurses (DeBack & Mentkowski, 1986), whereas others have refuted this notion and considered these programs different only in regards to the amount of education required (Kohnke, 1973; McCloskey, 1981). Many studies in the United States referred to BScN-prepared nurses as *professional nurses* and associate degree- and diploma-prepared nurses as *technical nurses* (DeBack & Mentkowski; Gray, Murray, Roy, & Sawyer, 1977; Kohnke, 1973; Waters, Vivier, Chater, Urrea, & Wilson, 1972). Accordingly, the knowledge base of technical nurses is narrow in scope, and they are primarily required to deal with the technical tasks of nursing, whereas the knowledge base of professional nurses is broad in scope and inclusive of cognitive skills besides technical skills, and they are required to deal with a wide range of nursing problems. In addition, professional nurses are also expected to practice in an autonomous manner and base their nursing-care decisions on scientific findings (Floyd, 2001; Ryan & Brewer, 1997; Young & Sowell, 1997). In summary, BScN nurses are expected to demonstrate a broader range of competencies than are those without baccalaureate education.

Given the importance of basic nursing education programs for practice, numerous studies have been conducted in the developed countries to evaluate the outcome and /or impact of baccalaureate degree nursing programs in the nursing workforce (Bartlett et al., 2000; Clinton et al., 2005; Field, 1978; Johnson, 1988; McCloskey, 1983; Parker & Humphreys, 1973; Ryan & Hodson, 1992; Waters et al., 1972). Most of these studies looked at the graduates' job effectiveness, performance, or clinical competence. Nevertheless, the nursing literature presented mixed evidence of BScN nurses' performing better in practice. Some researchers reported that, in comparison with graduates of diploma or associate degree programs, BScN graduates have a broader range of competencies (DeBack & Mentkowski, 1986) and/or that they perform better in regards to certain skills (Johnson, 1988; Bartlett et al., 2000; Beeken, 1997; Ryan & Hodson, 1992) such as critical thinking, communication, and problem solving. However, other researchers (Boggs, Baker, & Price, 1987; Clinton et al., 2005; Joyce-Nagata et al., 1989; McCloskey & McCain, 1988) found no major differences in the competence of nurses educated in different programs. Poster et al. (2005) illustrated that the differentiation between BScN versus non-BScN lies in the scope of practice.

The aforementioned inconsistencies in the findings in regards to the outcomes of BScN programs may be attributed to various factors, particularly conceptual and methodological issues in measuring competence (McCloskey, 1981). Although competence may be measured as an outcome of a nursing program (DeBack & Mentkowski, 1986; Kapborg & Fischbein, 2002), there is no single way of conceptualizing and measuring competence (Gonczi, 1994). Given the fact that competence is an abstract, complex, and dynamic concept (Eraut, 1998; Manley & Garbett, 2000), the variations in the results of studies exploring competence are not surprising. Consequently, studies in which competence is measured may or may not indicate that nurses holding baccalaureate degree are different from those without baccalaureate degree; it depends on which variables are being measured (Bartlett et al., 2000). Differences in the results may also be attributed to how competence is measured as well as from whose perspective. Because competence is viewed as a measure of quality (Eraut, 1998), the meaning of competence will vary with the perspectives of those who define it because *quality* is a relative concept and hence reflective of individual taste based on beliefs and values that may be specific to the context and/or culture (Kueng, 2000; Suh, 2004). Considering this information, it is appropriate to conclude that graduate competence is a context bound phenomenon that must be assessed from its stakeholders' perspectives in order to determine the program effectiveness (Kapborg & Fischbein, 2002).

Ryan and Hodson (1992) suggested that regardless of the research methodology and measurement criteria, evaluation of graduates from their employers' perspective is a critical component of program evaluation. Employers are in a better position than other stakeholders are to appraise the relevance and outcomes of educational program as well as the quality of graduates. Therefore, employer evaluation of graduates' competence is a major element in the summative component of program evaluation and is considered necessary for curriculum development or modification. Although the value of employer evaluation has been recognized in the nursing literature, some researchers indicated that total reliance on the employer evaluation could be limiting because the employers' views may be biased toward a specific model of nursing education (Hayter, 1971; O'Connor, Pearce, Smith, Voegeli, & Walton, 2001). Hence, including this study, many researchers of competence evaluation among staff nurses have considered graduates' self assessment together with their supervisors or employers' evaluation (Clinton et al., 2005; Fisher & Parolin, 2000; Meretoja & Leino-Kilpi, 2003; O'Connor et al.; Schwirian, 1978; Tzeng, 2004; Waters et al., 1972).

The BScN program at AKU-SON was implemented through an envisioning of its positive effects based on the experiences of many developed countries, but before this study, no systemic evaluation was done to determine the relevance and impact of a BScN program on the nursing workforce in a developing country such as Pakistan. Although a formative evaluation of the BScN program was conducted after its first year of implementation (Upvall et al., 1999) to solve the early problems of a new program and identify areas for improvement, no research was done after the graduates of the BScN program had entered the nursing workforce. Because nursing serves society and the needs of the community, it was important to identify whether the graduates of a BScN program were capable of meeting consumer expectations.

## Statement of the Issue

Although the issue of entry-to-practice qualifications is not new among the developed countries, it is an emerging issue for developing countries such as Pakistan. Nursing leadership in Pakistan appears to be divided on the importance of baccalaureate education in nursing. Some nurse leaders feel that entry-to-practice qualifications should be upgraded from diploma to degree education, but others disagree with the idea. Although the leaders realize the importance of a BScN education, they also fear that the degree-prepared nurses will be more readily recruited abroad. Furthermore, a BScN program certainly requires more resources, and the net gain from the program is doubted. In accordance with the registered nurse requirements of the Pakistan Nursing Council (PNC), the regulatory body of nursing, all of the nursing schools in the public sector of Pakistan offered a three-year diploma program until 2003 when two nursing schools began to offer a four-year BScN program. However, among the private institutions, AKU-SON initiated its four-year BScN program in 1997 in addition to the diploma and post- RN BScN programs that have been offered since 1980 and 1988 respectively.

The need for a BScN program at AKU-SON was driven by the limited number of degree nurses in the country and the predicted positive impact on the health care delivery system in Pakistan. Although the post-RN BScN program at AKU-SON has been able to prepare nurses with leadership skills that are sufficient for first-line management or teaching positions, the number of degree-prepared nurses through this route has been slow and insufficient to have a significant impact on the delivery of patient care. Often there is a time lag between nurses' earning a diploma and then deciding to return to school for their post-RN BScN degree, and another time lag before they decide to pursue graduate education. A sufficient pool of BScN nurses is crucial to recruit and prepare nurses at the graduate level who would be capable of serving in higher level management and teaching positions. Hence, it was envisaged that a BScN program would offer a speedy way of preparing nurses for leadership roles in addition to providing clinical competence (Pakistan Nursing Council, 1996).

Since the implementation of the BScN program at AKU-SON, a gradual increase in the enrolment in the program has been noted, but comparatively fewer students have enrolled in the diploma program. By 2004 the number of graduates from the BScN program had doubled (from 16 to 32) compared with 2001. These figures have financial implications for both the schools and the nursing services at AKU. Initially, it costs more to prepare a BScN nurse than a diploma nurse; similarly, BScN nurses at Aga Khan University Hospital (AKUH) receive about 10% higher salaries than do diploma nurses. This cost may be offset in the long run if the graduates can demonstrate the value of their added knowledge in professional practice. In other words, raising the level of nursing education at the entry level is envisioned as preparing nurses with broader knowledge and skills, which will have a potentially positive impact on nursing practice and the profession. More than three decades ago, Kohnke (1973) asserted that "additional education does not confer automatic status on any one of us; rather it provides us with an additional knowledge base which can extend our services to people" (p. 1575). Many other scholars have echoed this assertion and contended that the envisioned impact of baccalaureate education in nursing must be realized by its consumers (Beach, 2002; Girot, 2000a; Upton, 1999). Hence, those striving for extended knowledge should be rewarded, but the profession and the public should also benefit from their extended knowledge. Therefore, it was imperative to explore and describe the professional competence of BScN graduates and its impact on the nursing workforce.

Because the post-RN BScN program at AKU-SON is offered to experienced nurses, most of the graduates are capable of working in first-line management or teaching positions on completion of the program. The nurse educators at AKU-SON hope to see similar performance from the graduates of the four- year BScN program once they gain some experience as nurses, as BScN graduates enter the workforce with their educational clinical experiences as their only nursing experience. Since a number of BScN graduates are now in the workforce with more than two years of experience, one can systematically attempt to identify whether such expectations are realistic or not. There is some evidence in the literature that nurses with a BScN degree or a post-RN BScN—RNs who obtain a BScN degree after some work experience perform at a similar level, but they may differ in their commitment to the nursing profession (Chornick, 1992; Lawler & Rose, 1987). Chornick compared post-RN BScN graduates (n = 4166) to BScN graduates (n = 7718) in regards to patient care and the degree of commitment to the profession and found that graduates of the two programs did not differ in providing patient care, but post-RN BScN graduates demonstrated professional commitment more frequently. Nonetheless, in this study commitment was measured in terms of nurses' attitudes towards professional development, such as attending continuing education programs and furthering their education.

Prior to conducting this study, anecdotal accounts from nursing services personnel at AKUH indicated that BScN graduates have better knowledge and communication skills than do diploma graduates, but that BScN graduates lacked professional commitment to a nursing career. Some informal discussion on this issue revealed that nursing-services personnel gauged professional commitment on the basis of the turnover rate of BScN nurses at AKUH. According to the director of nursing services (Khowaja, K, personal communication, April 12, 2005), the turnover rate for diploma nurses was 24%, whereas for BScN graduates it was 31%. However, associating turnover rate with lack of professional commitment among BScN graduates may be disputed because nurses' turnover has been a chronic issue at AKUH. For instance, the turnover rate for nurses in general was almost 34% from 1996 to 1999 (Khowaja & Nensey, 1999). One of the major underlying factors in this high rate is the migration of nurses to developed countries. Haddad, Al-Mohandis, and Mughal (2005) noted that "nearly 70% of nurses [at AKUH] are novice . . . . This situation creates grounds for conflicts and faster rates of burnout" (p. 8) that may lead to high turnover rate.

The high turnover rate of nurses at AKUH may be associated with their commitment to the institution, but nurses' turnover is a global phenomenon that is influenced by a variety of personal and contextual factors (Cline, Reilly, & Moore, 2004; International Council for Nurses, 2003; Kline, 2003). Furthermore, although a lack of interest in working at a particular institution will lead to a high turnover rate, it does not necessarily mean a lack of commitment to one's career or profession unless one leaves the profession completely. At times people may leave a position for further professional development opportunities or if the profession is better valued in another country than their own (Buchan, 2001).

In a recent study, Khowaja and her colleagues (Khowaja, Merchant, & Hirani, 2005) found that nurses were dissatisfied with their work at AKUH because of "stress associated with high workload, biased Nursing Management, lack of appreciation and monetary incentives, . . . [and] a rigid attitude of Nursing Management" (p. 32). Such contextual issues could possibly affect nurses' ability to actualize their potential because the application of knowledge in practice is heavily influenced by its context (AbuGharbieh & Suliman, 1992; Aiken et al., 2001). Graduates of baccalaureate programs may be prepared with certain knowledge and skills; however, the knowledge and skills may not have any impact on patient care or the nursing profession unless the context in which nurses function allows for application of the learned knowledge and skills. Smith (2002) analyzed BScN and non-BScN nurses' tasks, and her findings revealed that both groups of nurses were required to perform more basic-care activities than teaching and leadership/management activities. The author concluded that because basic care of patients will always take precedence over other activities such as teaching, variability within nurses' expected work is limited even though nurses at the BScN level are prepared to perform different tasks. In view of the above information, it was necessary to adopt a comprehensive approach to assess the competence BScN graduates in the nursing workforce before making any conclusion about the outcome of BScN program at AKU-SON.

## Purpose of the Study

The purpose of this study was to explore and understand experiences and perceptions of the BScN graduates and their supervisors of the graduates' competence in the nursing workforce at Aga Khan University. Additional purposes of the study were to explore the differences in perception of the expected and actual performance of BScN graduates at AKU and, in light of the findings, to make recommendations in regards to future planning of prelicensure educational programs at AKU-SON. Specifically, this study was planned to answer the following questions:

1. How do BScN graduates describe and demonstrate their professional competence?
    - What is the graduates' experience and views about their competence?
    - What is the perception of competence about BScN graduates from their supervisors' perspectives?

2. What is the perceived contribution of the pre-licensure BScN program at AKU-SON to its graduates' professional competence?
3. What roles are being played by the BScN graduates in the nursing workforce at AKU?
4. What factors facilitate or impede the potential competence of graduates in their nursing practice?

## Significance of the Study

Although extensive information is available in the literature about the competence of graduates from BScN programs and its impact on nursing profession, as stated earlier, none of the studies have been conducted in the context a developing country, such as Pakistan. The study was the first of its nature to be conducted in Pakistan. Even though AKU-SON has been offering the four-year BScN program since 1997, no study had been conducted to follow-up on how graduates perform in the nursing workforce after completion of their program. It is hoped that the findings of this study will offer strategic guidance to AKU-SON with regard to its future planning for pre-licensure educational programs and curriculum development. These findings will also provide some guidance for the nurse leaders in their current debate on entry-to-practice qualification for nurses in Pakistan. I envisage that the information acquired through this study will be useful not only for Pakistan, but also for the nurse leaders and policy makers in other countries in the region who share similar socioeconomic and political challenges. Finally, this study will generates baseline information for future research and should contribute in the development of professional nursing education in Pakistan.

## Context of the Study

Considering the phenomenon under investigation in this study, competence of BScN graduates, it is necessary to describe the different layers of context in which these graduates are required to practice. The major layers of the context may be conceptualized in terms of the broader culture in Pakistan and the nursing culture in the country and at AKU, which includes the nursing school (AKU-SON) as well as the Aga Khan University Hospital (AKUH). Each of these layers is influenced by sociohistorical, structural, and political factors. These layers may also play a role in shaping the experiences of graduates in nursing workforce.

## *Pakistan as a Country*

### *Sociohistorical Overview*

Situated among India, China, Afghanistan, and Iran, Pakistan came into existence in 1947 when British colonization ended on the subcontinent of India. At that point India was divided into two different states, Hindustan (India) and Pakistan. The division was based on the people's religious affiliations, mainly Hindus and Muslims. More than 90% of Pakistan's population is Muslim of different sects including Sunnis, Shi'as, Bohras, Deobandis, Ahl-e-Hadis, Ismailis and others. The country currently has over 153 million people, with a continuous population growth rate of 1.9%-2.5% per year (UNICEF, n.d.; World Health Organization, 2004). The people of Pakistan have diverse ethnic backgrounds, with more than 20 dialects being spoken throughout its four provinces and federally administered areas. Although the national language of Pakistan is Urdu, English is widely used for instructional purposes in higher education and professional institutions, as well as for commercial, legal, government, and official business in the country. Hence, English is the de facto official language (Amarsi, 2003; Pakistan - Linguistic and Ethnic Groups, 1994). In terms of the country's administrative structure, social development policies for education and health are created at the federal level, but implementation of the policies is the provincial governments' responsibility.

The majority of Pakistan's population (66%) lives in rural areas. Many people prefer to live in an extended-family structure, particularly in rural areas. Marked disparities are noted in the infrastructure of rural and urban areas (UNICEF, n.d.; World Health Organization, 2004). As a result, people from rural areas are attracted to urban areas, which creates overcrowded cities. The per capita gross national income products (PCGNI) in US $ is 470 for Pakistan, which is much lower than that of a developed country such as Canada ($20,510), but comparable to that of its neighboring countries, such as Nepal ($240), Bangladesh ($400), and India ($530) (UNICEF, n.d.). In Pakistan, approximately 82% of the people have access to safe drinking water, and only half of the population have a safe sanitation system (World Health Organization, 2004). However, with the extensive social disparities and distribution of income, 30% of the people live below the poverty line. Unfortunately, corruption is alleged to be prevalent in almost all official institutions, including the police and the judiciary system, which therefore maintains or enhances the social disparities (ul Haq, 1997). In addition, the social segregation of people based on their class is also noticeable, which is contrary to the teaching of Islam. Lee and Saeed (2001) contended that the roots of the "Hindu caste system, present in Pakistan prior to partition" (p. 18), continues to foster the unequal power structures on the basis of social class and gender. In other words, the social norms of Pakistan are influenced by various factors besides the religion of Islam.

The rapid rate of population growth has been a continuous challenge for the government as it attempts to overcome the disparity between the availability of resources and demand. In addition, since partition, an unresolved conflict between India and Pakistan has existed, so more of the government funds are spent on defense and military support rather than on social services such as education and health care. On average, the total expenditure on health and education is less than 5%, compared with that of defense, which is around 28%. The civil unrest and repeated wars in Afghanistan have also led millions of people to take shelter in Pakistan. The extensive migration of people has not only overstretched the existing resources of Pakistan, but also escalated the drug and ammunition culture (Amarsi, 2003).

### *Health Care Resources and Challenges*

Despite the fact that health care in the public sector is supposedly free, only 60% of the population in Pakistan has access to reasonable health care (ul Haq, 1997). A three-tier infrastructure of the public health care system was set up in the 1970s (Harnar, Amarsi, Herberg, & Miller, 1992) that consists of different levels of health care from the villages to the cities, such as basic health units (BHUs) in the villages for primary health care, the Tehsil and district hospital for secondary level health care, and provincial and teaching hospitals as the referral units that provide tertiary care (see Table 1).

Although this is an excellent system on paper, it is not functional because of mismanagement and corruption (Khan, Gul, & Khan, 2000). In many areas the BHUs are only structures without sufficient staffing and supplies. The BHUs were built in large numbers in remote areas without supportive structures such as schools and proper residences, and physicians and other staff have never wanted to work in them. Although insufficient for the demand, most of the physicians and nurses are deployed in tertiary care facilities in urban areas, leaving the rural areas extremely underserved. In many of the remote areas lady health visitors (LHVs) (Upvall, Sochael, & Gonsalves, 2002b) or lady health workers (LHWs) are the sole health care providers.

Table 1

*Pakistan's Health Care System*

| **Structure** | **Primary level** | **Secondary level** | | **Tertiary level** |
|---|---|---|---|---|
| Scope of the facility | Basic health unit and MCH centers | Rural health center | Tehsil health & district hospitals | Provincial teaching & special hospital |
| Population coverage | 10, 000 | 300,000 | Up to 400,000 | 1.5 Million |
| staff | Physician, LHV, CHWs | Physician, LHV, CHWs | Physician, RNs, LHV, CHWs | Physician, RNs, LHV, CHWs |
| Beds | Day clinics | 10-15 beds | 15-30 | 300 - $\geq$1000 |
| Nature of service | Preventive & simple curative | Preventive & curative, support for BHU | Medical/surgical expertise, diagnostic & referrals facilities | Major medical/ surgical specialties for adult & children |

(Adapted from Harnar, Amarsi, Herberg, & Miller, 1992)

According to the World Health Organization (WHO, 2004), Pakistan has 7.3 physician and 4.7 nursing and midwifery personnel per 10,000 population. The nursing and midwifery category includes nurses, Lady Health Visitors, and midwives. The scarcity of resources may be explained by the fact that the total government expenditure on health is approximately 1% of the gross national product (GNP). This percentage is very low in comparison with not only a developed country such as Canada, which spends about 10% of its GNP on health, but also other developing countries such as India, Nepal, and Iran, which spend about 1.6%, 4.7%, and 7. 9%, respectively (Amarsi, 2003), on health care. Insufficiency of resources is a genuine issue in health care in Pakistan; however, the lack of planning and mismanagement of existing resources make its access more difficult for the most needy population.

Considering the limitations of the public health care system, upper- and middle-class people usually use the private health care system, which has been flourishing over the past three decades, whereas those unable to afford private health care are forced to resort to homeopathic medicine, faith healing, or quack medicine. In the villages it is also not uncommon to see fake doctors, who may have spent some time in a hospital working as a drug dispenser, dresser, or nursing assistant and then present themselves as doctors. Such practices can help people at times, but the dangerous consequences of fake medicine are not rare. With the lack of law and order and people's awareness in general, fake doctors continue to practice without penalty.

With inadequate public health facilities and health care system, Pakistan is faced with a double-disease burden. Although infectious diseases have been a continuous challenge for the country, the increasing rates of heart disease, diabetes, renal disease, and mental health problems are also evident. Diseases such as tuberculosis and malaria that were thought to be well under control in the 1980s are once again on the rise. The infant mortality rate is approximately 84 per 1,000 live births, and the maternal mortality rate ranges from 200 to 700 per 100,000, with the highest rates among women in rural areas (UNICEF, n.d.; WHO, 2004).

### *Pakistani Culture and Society: Status of Women*

Pakistan may be characterized as a tribal, feudal, or hierarchical society (Fikree, Khan, Kadir, Sajan, & Rahbar, 2001; Lee & Saeed, 2001; Ministry of Women Development, 1998). However, traditionally, Pakistan is a patriarchal society, which basically defines the status of women. In general, female members of the family cater to the needs of the males from infancy to adulthood in their roles as mothers, sisters, or wives. Women are primarily responsible for household and reproductive activities, that is, child bearing and rearing, whereas men are responsible for productive activities and financial earnings (Khan, 2003).

Children, regardless of their age, are expected to stay with their parents; and daughters after their marriage are expected to live with their in-laws. Because Islamic teaching emphasizes modesty, it imposes certain restrictions on interactive behaviors such as touch with members of the opposite sex other than close family members (Ali, 1996). Because of these values and role expectations, in general, female employment in Pakistan is perceived negatively in society, particularly when females come into contact with men other than their blood relatives or spouse. In Islamic societies sexual relations before marriage are forbidden, but marriage is a highly valued norm. The same is true for Pakistan. A married women with few years of formal education may be more respected than an unmarried women with higher qualifications who is serving the community (Hemani, 2003). As a result, parents are usually more concerned about their daughters' marrying than their education or career. Such societal values affect the availability and quality of candidates for nursing.

As in many countries in the world, religion and culture are inextricably linked in Pakistan and form the basis for women's marginalization in society (Lee & Saeed, 2001). Commenting on the status of women in Pakistan, Khan (1986) explained, "The authority of older over younger and men over women supported in Islam is strongly displayed in the society. . . . Women are viewed as the property of men to whom they are related" (p. 41). Engineer (2004) pointed out that not all rights of women as detailed in the *Qur'an*—the holy book of Muslims—are necessarily cherished by society, but the supremacy of men over women is strongly emphasized. On one hand, men make decisions pertinent to education, marriage, and childbearing for women. In many ways women are considered less important than men; for example, they are the last ones in the family to be fed. On the other hand, women are symbolized as the '*honor*' of the family who must therefore be guarded or protected by the male members of the family from the harshness of life outside their houses. In many families, women are accompanied by a male member of their family for any activities outside their home, such as shopping or visiting a physician. Such practices instigate dependency behavior among women and enforce supremacy of men over women regardless of the intentions. The prescriptions of roles by gender could be associated with Islamic teachings; however, both genders are given equal rights in the *Qur'an* in terms of education, marriage, and childbearing, but equal rights are almost denied in cultural practices. Nonetheless, in general religion is exploited according to personal preference.

It is important to note that although the existing laws and practices in Pakistan reflect the discrimination and marginalization of women, different interpretations of gender and gender-related practices are observed within the same country. The variance in acceptable behavior for women can range from practicing the principles of *purdah* (seclusion) to complete freedom of movement and interaction with others, including the choice to work outside the home and participate in public life (Goodwin, 1995; Mumtaz & Shaheed, 2005). These variations are permitted by society, but people respond differently based on their subcultural group, especially the dominant male group (Lee & Saeed, 2001), which is strongly reflected in the sociocultural indicators of the country.

Although the literacy rates overall are low in Pakistan (43%), the rates for females (28%) are significantly lower than those for males (57%) (ul Haq, 1997; UNICEF, n.d.) because preference is given to males' education over that of females; men are considered to be the economic asset for family. Thus the enrollment of girls in primary education is 35% compared to 63% for boys.

On average, a Pakistani woman bears 5 or 6 children. Unlike life expectancy rates in other developed and developing countries, the life expectancy of women in Pakistan is lower than that for men: 61 versus 63 years. Hence, in South Asia, Pakistan ranks the lowest in terms of most of the gender-related development indicators (ul Haq, 1997).

As in many other countries, nursing in Pakistan is predominantly a female profession; hence the low status of women in Pakistani society impacts significantly on the image of the profession. The early socialization of Pakistani women may be at odds with the characteristics needed by a professional nurse. It is certainly challenging for Pakistani women to act as independent practitioners who are expected to think critically, use professional judgment, and communicate assertively when they have learned to serve, obey, and rely on the judgment of males through their early socialization in life.

### *The Profession of Nursing in Pakistan*

In many countries of the world nursing and midwifery services are the backbone of the health care system, representing over 50% of the health professions (World Health Organization, 1997). However, in Pakistan the ratio of trained nurses to the population is 1: 5,328 (World Bank, 1999/2000). It is one of the very few countries in the world (Wharrad & Robinson, 1999) that has an inverse ratio of nurses to physicians of 1: 6-7 (World Bank, 1999). Although nurses and midwives have played a significant role worldwide in the delivery of services, their potential has not yet been fully realized in Pakistan. The foundation of nursing in Pakistan began with compromises under challenging circumstances in 1947 and continued to develop under substandard conditions.

### *A Brief History of Nursing*

In the subcontinent of India, girls from Muslims and upper Hindu castes were not encouraged to become nurses. Hence, nursing had been predominantly a Christian profession in which many Christians in the subcontinent have become converts from the Hindu lower castes (Saleem, Shah, & Nagi, 1992). At the time of independence, most of the non-Muslim nurses migrated to India (Hindustan), whereas the British sisters returned to their country. The three nursing schools located in the area that became part of Pakistan were nonfunctional. During the same time thousands of refugees were arriving from India, and most were suffering from physical and/or psychological traumas because of the civil war and riots associated with the partition. With extensive demands for nursing care, the entire country of Pakistan had less than 100 nurses to face the challenge. In view of these circumstances, the newly formed government of Pakistan appealed to the nation to send its daughters into nursing. Although the country responded positively, there were no resources, especially teachers, as well as sufficient time to begin proper training. The general education of the candidates was another major issue. As result, women with reading and writing abilities in Urdu were trained to become nurses with only two weeks of training in basic nursing procedures (Hemani, 2003; Saleem et al., 1992).

In 1948 the first nursing school was established in Pakistan to offer a three-year general nursing program, and by 1952 only seven nurses were qualified from this program. The school was spearheaded by a physician, the medical superintendent of Sir Ganga Ram Hospital, with which the school was affiliated.

The first post-basic education program to prepare nurses for teaching and ward administration was offered in 1956. Initially, it was a combined program of one year's duration, and then it was developed into two separate diplomas, each one year long. Both of these post-basic diplomas were offered in a college located in the province of Sindh. Over the next three decades this college remained the single sources of nursing education at the post-basic level (Hemani, 2003; Saleem et al., 1992) even though the demand for more nurse teachers and managers was growing because of a steady increase in the number of hospitals and nursing schools for basic education. Higher education has remained mostly inaccessible to the majority of nurses in Pakistan (Upvall, Karmaliani, Pirani, Gul, & Khalid, 2004). Providing a detailed history of nursing is not the purpose of this chapter, but with some background information, it is easier to understand and appreciate the current status of nursing in Pakistan.

### *The Current System of Nursing Education*

Nursing in Pakistan includes three categories of personnel: nurses, LHVs, and midwives. There are currently 83 schools of nursing, 92 midwifery schools, and 20 public health schools to prepare nurses, midwives, and LHVs respectively (Upvall et al., 2002b). The minimum requirement for admission to these programs is matriculation (equivalent to the 10th grade). However, preference is given to candidates with 12 years of basic education if it is available. The duration of the basic nursing program or general nursing is three years, two years for the LHV program, and one year for midwifery. Nursing and midwifery schools are located in the armed forces and the public and private sectors, but all of the schools are regulated by the PNC. Hence, graduates of these schools are required to register with the PNC (as a registered nurse [RN], registered midwife [RM], or Lady Health Visitor [LHV]) upon completion of their program and passing of the provincial nursing board examinations. Nurses in public sectors are required to have both general nursing and midwifery before they can be eligible for post-basic education. Although co-education for male and female nurses is permitted at the post-basic level, it is prohibited by the PNC at the basic level of nursing education with the exception of the BScN program at AKU-SON because it comes under the jurisdiction of a University. Therefore, a number of separate schools in the public and private sectors provide nursing education to male nurses.

Nursing education in the government sector is free. Although variations exist among provinces, nursing students are provided monthly stipends that are equivalent to the basic salary of a staff nurse. Consequently, students in these diploma programs are utilized for hospital services. In other words, nursing education operates on the apprenticeship model in which a nursing student is not a student in reality, but an employee or apprentice (World Health Organization, 1956). Most of the hospitals in Pakistan do not have enough qualified staff; hence, it is not unusual to find nursing students working on their own without any supervision, especially during the evening and night shifts. Nursing students are expected to care for patients and make decision for which they are not sufficiently prepared. As a result students learn through the trial and error method which not only affects the quality of care patients receive but also contributes to the poor image of nursing.

Although the PNC suggests a ratio of 1 clinical teacher to 10 nursing students, no school can afford to maintain this ratio because of the scarcity of funds. Some schools have only 1-2 teachers for the entire school; and these individuals have both teaching and administrative responsibilities. Given this situation, students may receive the theory component of their courses from faculty and limited clinical supervision from staff nurses. Because some schools do not have enough teachers to cover even the theory component, physicians from the hospitals are invited to participate in nurses' education. Few schools have separate nursing and hospital administration, and for the majority of schools the nursing superintendent of the hospital is responsible for overseeing the school administration. As a result service takes precedence over students' education. Nursing students have little support to develop assertive or empowering behaviors, but rather are forced into learned compliance. They are abused not only by physicians, but also by senior members of the nursing staff (Lee & Saeed, 2001). In addition, what nursing student learn in the classroom cannot be practiced in the hospitals because of a lack of resources. For instance, many wards in hospitals do not have a regular supply of soap and water for hand washing (Kanji et al., 2001).

At the post-basic level, there are six colleges of nursing in the country that offer a variety of post-basic diploma programs. These one-year programs provide a Diploma in Ward Administration (DWA), a Diploma in Teaching Administration (DTA), and diplomas in other areas of specialization, such as anesthesiology, community health, intensive care, and pediatrics. RNs can take a DWA or a DTA with other specialization courses. As noted earlier, the first post-RN BScN and the first BScN were implemented in 1988 and 1997 respectively at a private university—AKU. In 2001 one of the nursing colleges in the province of Sindh began to offer a post-basic BScN degree after it became affiliated with a provincial university. Other colleges are seriously considering this model. However, recently, a few institutions including one in the public sector and one in Pakistan Armed Forces have begun to offer a BScN program. Moreover, some public universities in Pakistan offer a BSc degree to nurses at the post-basic level. To acquire this degree, nurses have to study three nonnursing subjects: English, Islamic, and social studies (Kanji & Stanley, 2001). Although this is a nonprofessional degree, nurses who work in the Middle East are given monetary incentives for this qualification. With this degree, nurses can enroll in master's-degree education in any subjects (non-nursing) that are offered by some public universities in Pakistan.

Nurses with any of the specialization courses are granted a special allowance; however, no provision is made within the government structure to recognize nurses with degree education. As a result, many nurses in the government sector who were sponsored by international donor agencies to obtain a degree from AKU-SON left the country after a long struggle for recognition of their advanced education. Although nurses having degree education are paid better at AKU and other private institutions in the country, a similar valuation of higher education is being awaited in the public system. In fact, some private institutions may pay even higher salary than AKUH to attract an AKU-SON prepared nurse for a teaching or leadership position.

Upvall and colleagues (2002a) noted that a DTA is required of nursing faculty who are teaching in government schools of nursing. However, no further continuing education or clinical practice is needed beyond that requirement. Nurses with specialization courses are not deployed according to their specialty; neither is the number of nurses in each specialization needs based. Amarsi (2003) contended that there is no coordination between planning, production, and deployment of nurses, which is reflective of health human resource management in the country.

### *Image and Status of Nursing in Pakistan*

The negative characteristics of the nursing profession in Pakistan outweigh its positive characteristics, which creates a low image of nurses. Gul (1998) reported that although 90% of the respondents in her study considered "nursing as a noble profession" and 92% acknowledged that "hospitals cannot function without nurses" (p. 49), less than 30% of the respondents considered nursing a suitable profession for their daughters or sisters. Gul also observed that the low socioeconomic status of nurses, the unsafe work environment, a lack of respect from physicians, and the nature of nurses' work create a dichotomy in society's attitude towards the nursing profession in Pakistan. Although Islam does not expressively prohibit the practice of nursing by females, it does emphasize modesty, which imposes certain restrictions on interactive behaviors with members of the opposite sex (Ali, 1996; Bryant, 2003). Because of this, many Muslim families do not view modern nursing as an appropriate profession for their daughters because nursing requires both close interaction with members of the opposite sex and work outside the home. In addition, work outside their home often includes night shifts, which is considered unsafe for women, especially when the worksites and hospitals provide little or no protection for women (French, 1991; French, Watters, & Matthews, 1994; Furrukh, 1962; Gul, 1998)

Medical dominance is a major worldwide issue that affects nursing's image and status in society (Pearson & Peels, 2001). Such dominance is more pervasive when coupled with the values of a male-dominated society such as Pakistan. Using an ethnographic approach to study nurses' work, Street (1992) described the medical dominance and its consequences for nurses and patients in Australia. She believed that "the legitimation of medical knowledge, practices, and ethics entails a concurrent devaluing of nursing knowledge, practices, and ethics" (p. 272). As a result, nurses lack autonomy because their work is subjugated and regulated by physicians. Lee and Saeed (2001) noted that nurses in Pakistan receive poor economic rewards for high-stress work and achieve minimal status or influence over matters of health and illnesses in society. The subjugation of nurses is perpetuated through the disadvantages of class and gender.

Marles (1989) maintained that much of nursing's occupational identity, lack of work incentives, and policy influence is embedded in what the community expects from the role of women. This is particularly true for the nursing profession in Pakistan. Most nurses are not skilled in the area of policy, leadership, and political activism (Morgan & French, 1993), and the lack of these qualities, which are critical for an effective leadership role, not only reflects nurses' educational preparation but also indicates their social status. Such limitations have a negative impact on the advancement and prestige of nursing. Furthermore, the negative portrayal of nurses in the media and low public awareness of nursing contributes to its low image. For instance, Gul (1998) found that in her study 20% of the physicians and more than 50% of the patients and members of the general public did not know that nurses receive three to four years of professional education.

In summary, although nursing in Pakistan shares various characteristics with the profession worldwide, multiple contextual factors, including socioeconomic, historical, structural, administrative, and political realities, shape the nursing culture in Pakistan.

### *Nursing at Aga Khan University*

AKU, charted in 1980, is a private, self-governing university with an international board of trustees. The first campus of AKU was established in Karachi, Pakistan, to create education and health programs and raise the status of nursing in Pakistan. Therefore, the University began with a school of nursing (AKU-SON) as its first academic constituency, followed by a medical college (AKUMC) and the hospital (AKUH). AKU has acquired the status of an international university, with 10 teaching sites in seven countries: Pakistan, Kenya, Tanzania, Uganda, Afghanistan, Syria, and the United Kingdom. The university administration is extremely supportive of higher education for nurses.

Nursing education at AKU currently consists of a three-year diploma program, a two-year Bachelor of Science in Nursing program for diploma prepared registered nurses (post-RN BScN), a four-year Bachelor of Science in Nursing program (BScN) leading to entry in to nursing, and a two-year Master of Science in Nursing (MScN) program. Apart from the diploma program, AKU-SON has the honor of being the first nursing school in the country to have established undergraduate and graduate degree programs in nursing.

In concurrence with its chancellor's vision, AKU-SON aims to provide leadership in nursing education, practice, administration, and research, thereby enhancing the status of the nursing profession in Pakistan (Miller, 1996; Vellani, 1994). Compared to other schools in the country, AKU-SON has the best infrastructure and resources, both human and financial. Unlike the prevailing apprenticeship model of nursing education in Pakistan, AKU-SON's standards are comparable to those of Western countries. Similarly, the school has a separate administrative structure from the hospital. Faculty members of the school plan and assume responsibility for all nursing educational programs offered by the school. The Director of Nursing at AKUH reports to the chief executive officer of the hospital whereas the Dean of AKU-SON and AKUMC reports to the provost of the University. Like physicians, nurses from the hospital and the school are represented at all levels and committees within the university structure. An extensive liaison exists between

AKU-SON and nursing services at AKUH. Nurses from the hospital have membership in various committees at the school and vice versa.

AKU-SON aims to prepare nurses who are capable of providing safe and competent care and who explicitly value quality, human worth, holism, ethical conduct, and cultural sensitivity (The Aga Khan University School of Nursing, 2005). In accordance with the school's mission, the quality of nursing education and the provision of opportunities for professional development for nurses are considered highly important. For instance, AKU-SON is the only institution in Pakistan where students work as supernumeraries to the nursing workforce. During the school semesters, students at the undergraduate level are accompanied by their course faculty for clinicals at various health care institutions including AKUH. However, during the summer and winter breaks students are assigned to various units at AKUH to gain clinical experience. Students work with the unit staff and are supervised by the unit head nurse who liaises with a faculty member on daily basis. Unlike the nursing education system in the public sector, students are expected to pay for their education at AKU-SON, but the cost is heavily subsidized by the university. In addition, students are given loans and /or grants to support their education. There are marked differences in the student and faculty resources at AKU-SON compared with other nursing institutions in Pakistan.

The majority of AKU-SON graduates seek employment within various constituencies of the university, including the school, hospital, and community health sciences. Some of the graduates are employed by other nursing institutions in the country in leadership positions. However, about 60% of nurses who resign from AKUH migrate to the developed countries especially the UK and USA (Khowaja & Nensey, 1999). In spite of such a brain drain, slowly but surely the impact of AKU-SON on the nursing profession is being realized in the country, and the input of nurse leaders from AKU is appreciated in the development of nursing in Pakistan.

***The BScN program***. The four-year BScN program was started in 1997 while the school maintained its diploma program. In the first cohort a total of 31 students, including 6 males, were admitted into the program. Out of the 31 students, 10 left the program within the first year (Upvall et al., 1999), and another 5 exited the program in their third year. Hence, in the first cohort about half (16) graduated in 2001. Upval and colleagues identified various reasons for students' attrition, including family factors such as migration or the need to help family with finances. Some students could not meet the academic requirement for continuation. Furthermore, one student joined a medical college, and another student left because of a disinterest in nursing. The attrition rate of students in first cohort of BScN program was extremely high compared to that of all subsequent cohorts. Students in the four-year BScN program are similar to diploma students in some respects, but different in others.

Although both groups enter nursing with no prior nursing experience, the admission criteria for BScN students is more rigorous than the admission criteria for diploma students. BScN candidates must have a Grade 12 education, with higher final grades than diploma students require. Although a Grade 12 education is also preferred for diploma students at AKU-SON, students may enter with Grade 10 preparation. The entrance exam for diploma students includes English and mathematics, where a science component is also required for BScN students. The program objectives for BScN students aim for a higher level of learning and are consistent with those of the post-RN BScN program. However, the leadership expectations between the two types of BScN graduates are different. Post-RN BScN students are expected to assume leadership positions at the end of the program, whereas the generic BScN graduate are prepared for generalist clinical positions in primary, secondary, and tertiary care settings (Upvall et al., 1999), but will be capable to function similarly to post-RN BScN graduates after some experience in the field.

In view of the above-mentioned expectations of BScN graduates, they are required to take all of the humanities and clinical courses that are offered to diploma students, but must also take additional courses that are part of the post-RN BScN curriculum. These include health assessment, pathophysiology Level 2, ethics and professional development in health care, society and health, behavioral psychology, principles of teaching/learning, nursing research and bio statistics, and advanced concepts in nursing. Likewise, the students are required to take an advanced-English writing course and one additional clinical practicum course of 270 hours. This practicum course is of an elective nature; students need to identify an area of interest and negotiate a placement with a clinical preceptor in consultation with the course faculty member. (The

Aga Khan University School of Nursing, 2005). In terms of total clinical hours, students in the diploma program do 2997 hours and students in the BScN program do 3951 hours.

In the first and second years of the programs, BScN and diploma students take the same courses. Articulation with post-RN students commences with specified courses in the third and fourth years. However, it is important to note that, in spite of diploma and BScN students' having a similar course grid in their first and second years of the program, different teaching strategies are employed, such as the tutorial or seminar method instead of lecture. Furthermore, higher assessment expectations are set for BScN students. For instance, the minimum passing percentage for BScN students in their nursing courses is 60%, whereas for diploma students it is 50%.

The delivery of curriculum for BScN students has been a creative endeavor for AKU-SON faculty. An evaluation of the BScN program after one year of implementation indicated multiple challenges for AKU-SON faculty in terms of integrating a new type of student population with diploma students (Upvall et al., 1999). Upvall and colleagues found differences in the two groups of students in areas of class preparation, motivation, self-direction, and communication abilities and reported that faculty perceived diploma students to be 'less vocal' in the presence of the generic students. The BScN students were more vocal, confident, and self-directed in their studies. The faculty also reported that there was a distinct feeling of differentiation between the two groups. The diploma students were intimidated by the BScNs, who felt superior to them. Faculty accounts also indicated that the BScN students had a sense of pride that was missing in the diploma students. As a result, the BScN students dominated the group, and the diploma students felt suppressed.

The hospital staff who participated in the study also noted differences in characteristics and attitudes (Upvall et al., 1999). They identified a sense of differentiation rather than collaboration between the two groups of students and indicated the implications. The staff appreciated the positive characteristics of BScN students, such as their self-directedness, confidence, and efforts at in-depth learning. However, they were concerned about the students' lack of helping behavior. For instance, the students were vocal in refusing to run errands on the unit that, from their perspective, did not contribute to their learning needs, such as taking a specimen to the lab or retrieving a report from there.

The results of Upvall's (1999) study highlighted important areas for faculty consideration, and since then different methods have been introduced to socialize BScN students with diploma and post-RN BScN students inspite of the fact that they are taught separately in most of their classes. However, no research had been conducted to evaluate how these graduates function after completing their programs and how their supervisors or colleagues in the workforce view their contributions. This study was planned to explore and understand the experiences of the graduates of the four-year BScN programs and their self perception of competence. In addition perceptions of supervisors about these graduates were also examined.

## Summary

In this chapter I have identified the importance of baccalaureate-degree education in nursing and have highlighted its associated challenges at a global level. Moreover, I have provided the background for undertaking this study. In addition, I have underscored the three layers of context: the broader culture in Pakistan, the nursing culture in the country, and organizational culture of Aga Khan University, which is influencing the beginning of BScN education in Pakistan. Finally, the purpose, questions, and significance of the study are described in this chapter.

# CHAPTER TWO:
# LITERATURE REVIEW

The review of relevant literature is divided into four sections. The first section, "The Concept of Competence: Definitions and Description," provides a general analysis of the concept of competence. This section begins with the importance and relevance of competence for nursing professionals and then highlights various definitions and descriptions of competence in various practice disciplines, including nursing. Terms that are associated with competence, such as *capability*, *performance*, and *competency* are also discussed in this section. The second section, "What Constitutes Competence in Nursing?," elaborates on the evolution of the meaning of competence in nursing as well as the characteristics and attributes of competence described by nurse scholars. The third section, "What Factors Influence Competence?" identifies the multiple factors that influence competence, but mainly societal, personal, educational, and contextual factors. The final section, "How Competence May be Assessed," focuses on various ways of assessing competence and its associated challenges. This section explains that in assessing competence, a researcher is required to make decisions at four points: the conceptualization of the construct to be measured, the selection of a measurement paradigm, the identification of measuring instruments, and the interpretation of the measurement data.

## The Concept of Competence: Definitions and Description

Competence is a broad, complex, and evolving concept, and it is defined in different ways by different people with social, professional, economic, and political connotations. In 1973, more than three decades ago, McCleary (as cited in Gale & Pol, 1975) asserted that "no group can claim professional standing without explicit statements about what constitutes competence in the field and the means by which competence is obtained and assessed" (p. 20). Although no professional will argue this assertion otherwise, researchers in various practice professions have had great difficulty in defining the concept of *competence* because of its inherent complexities (Epstein & Hundert, 2002; Eraut, 1998; Meretoja & Leino-Kilpi, 2001; Robb, Fleming, & Dietert, 2002; Short, 1984; Watson, Stimpson, Topping, & Porock, 2002; While, 1994). Consequently, various definitions of competence are found both within and outside the profession of nursing, which may lead to considerable confusion and misinterpretation. In general competence may be defined as the integration of knowledge, skills, attitudes, judgment, and abilities of a person exhibited in a specific role and or situation. In other words, competence is linked with a position or role; hence, the conception of competence is contextual as well individualistic. However, competence is a nebulous concept because it is defined in different ways by different people (Watson et al., 2002).

In a simple sense, a *concept* means a thought, notion, or idea. Burns and Grove (1997) defined concept as "a term that abstractly describes and names an object or phenomena, thus providing it with a separate identity or meaning" (p. 138), such as anxiety, hope, pain, or competence. Characteristics or attributes of a concept help to differentiate one concept from the other (Morse, 2000). In other words, a concept is an abstraction or conceptual representation of a phenomenon which helps in communication (Burns & Grove, 1997; Polit, Beck, & Hungler, 2001). A *phenomenon* refers to "a thing (a quality, a relation, a state of affairs, an event, etc.) as it appears to us, as it is perceived" (Burns &Grove, 1997, p. 319). Phenomena are observable facts or events. Concepts vary in their level of abstraction, "that is, in the number of inferential steps required to translate the observations into meaning" (Waltz, Strickland, & Lenz, 1991, p. 32). The more abstract the concept, the more difficult it is to measure (Burns & Grove; Waltz et al.). Concepts may be simple or complex. Complexity of a concept means the number of observable properties, characteristics, or behaviors that one may associate with a given concept (Waltz et al.).

Gonczi (1994), identified three ways of conceptualizing competence: (a) the task-based or behaviorist approach, which requires "direct observation of performance" (p. 28) for evidence. For instance, the ability of a nurse in dressing a wound or giving medicine following certain principles; (b) the generic competencies or skills approach, which relies on building general, underlying, transferable attributes of the practitioner "that are crucial to effective performance" (p. 29), such as critical-thinking capacity, or leadership abilities; and (c) the relational or holistic approach, combining a range of general attributes (with cognitive, affective, and psychomotor dimensions) in a way that addresses the needs of the practitioner in a specific context. The holistic approach is considered inclusive of performances and levels of sufficiency (Short,1984). In this study, I conceptualized competence in a holistic sense.

Eraut (1994; 1998), an educator with extensive work on professional competence, noted that competence has a range of meanings based on the context in which it is used. However, in general, competence may be viewed in two distinct ways (Eraut, 1998): (a) as a socially situated concept: "the ability to perform tasks and roles to the expected standards" (p. 127); and (b) as an individually situated concept: "a personal capability or characteristic" (p. 127). To elaborate, he explained that, at the general level of a profession or trade, referring to a person as "competent" usually implies some satisfactory service or that there is nothing detrimental about the person's ability to perform the job. Similarly, when a particular occupation is mentioned, such as a solicitor's competence in handling divorce cases, it implies that the solicitor is an expert in his/her job based on qualifications. Nevertheless, the listener may also make inferences based on his/her personal views, for instance that the solicitor should be equally competent in handling other dispute matters. So transferability is an expectation of professional competence.

The above-stated examples suggest that competence might mean a safe level of practice or having expertise in undertaking specific work, or it might simply refer to qualified people. Therefore, competence may be viewed as a measure of quality (Eraut, 1998; Parse, 2003), albeit with varied meanings. For instance, in some situations competence may be interpreted with a binary meaning as to whether someone is competent or not under the behavior approach to conceptualizing competence, whereas in other situations competence may refer to the minimum level of independent performance that is less than an excellent or expert level of performance (Benner, 1984). It is important to note that *quality* is a relative concept because it is reflective of individual taste based on beliefs and values that may be specific to culture (Kueng, 2000; Suh, 2004), or profession (Bradshaw, 2000; Smith, 1998). In view of this, if competence in professional practice is considered as a measure of quality, then the meaning of competence will vary with the perspectives of those involved in defining it because quality is a valuation of performance and reflects expectations and beliefs. In other words, being competent refers to a level of achievement, and quality is the evaluation of that level. Hence, it necessitates, as Eraut maintained that "the precise meaning of competence must be negotiated by its stakeholders in a macro or micro political context" (p. 127).

In defining competence with regard to health care professionals, negotiation may be required among professional associations, educators, employers, the government, and consumers of care/service. Such negotiation is considered crucial, especially when stakeholders are driven by conflicting values. For instance, when employers are driven by economic efficiency and professionals are driven by the ideology of their profession (Bradshaw, 2000; Manley & Garbett, 2000; Smith, 1998; Tzeng & Ketefian, 2003). Although clients/patients are considered one of the major stakeholder groups in health care because they are directly affected by the competence of health professionals, they are rarely involved in such negotiation. However, their interests with the professionals are indirectly negotiated by employers (Eraut, 1998).

Alfaro-LeFevre (2002) identified three dimension to indicate nurses' competence, that is knowledge and critical thinking (what to and why to); technical and interpersonal skills (how to); and caring (willing to, and able to). In medicine, Epstein and Hundert (2002) defined competence as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of individual and the community being served" (p. 226). The authors stated that their definition is reflective of seven dimensions of competence, that is: cognitive, technical, integrative, context, relationship, affective/moral, and habits of mind (p. 227). Although the preceding definitions appear different at a glance, they are similar in regards to indicating that competence is inclusive of cognitive, affective, and psychomotor elements. However, these authors differ in their description of dimensions and their level of elaboration. For instance, Alfaro-LeFevre's definition combines technical and interpersonal skills under one dimension of "how to" while Epstein and Hundert's definition present relationships and technical as two separate dimensions of competence.

Besides the above mentioned differences in defining competence by different scholars, an array of terms or concepts are found in the professional literature, that are associated with the term competence, such as competency, ability, capability, productivity and performance. Although the associated concepts add to the complexity of defining competence, it provides some explanation for various ways of conceptualizing competence. Considering this, the associated concepts of competence are discussed in the proceeding sections under two headings: (1) *Competence, Capability, and Performance* and; (2) *Competence and Competency.*

## Competence, Capability, and Performance

The *Oxford English Dictionary* (2005) defines competence as "sufficiency of qualification; capacity to deal adequately with a subject" (4 a ) and performance as "The carrying out of a command, duty, purpose, promise, etc" (1). Concurrent with these definitions, some scholars in nursing (McCloskey, 1981; While, 1994) as well as in other disciplines maintained (Messick, 1984; Newble, 1992) that competence is the potential or preparedness to act while performance is the actual action. Hence, they considered it two separate concepts, but an increasing number of scholars subsume the concept of performance into competence and hold a broader view of competence (Abruzzese, 1996; DeBack & Mentkowski, 1986; Gonczi, 1994; Epstein & Hundert, 2002; Meretoja, Isoaho, & Leino-Kilpi, 2004; Swanson & Chapman, 1994; Worth-Butler, Murphy, & Fraser, 1994).

McCloskey (1981) argued that although, education literature has referred to competence as an outcome of nurse education programs, the evidence that competence is always translated into actual role performance is limited. Many personal and contextual factors may explain the gap between competence and performance, such as work habits, anxiety, low motivation, and the workload of the professional. Likewise, Newble (1992) differentiated competence from performance by stating that the former is one's ability "to do at an expected level of achievement' and the latter is what the person "does in real practice" (p. 504) under a given set of existing circumstances. Another researcher—While (1994) echoed these views and argued that instead of competence, performance should be the focus of a practitioner in real life because one needs to assess performance to infer competence. Moreover, Katz (1992) regarded performance as a broader concept than competence. In her view performance is composite of competence and productivity. To her, having correct knowledge, skills, and attitude is competence and the application of these "at the right time to effect the right result is productivity. Competence without productivity is useless" (p. 298). Like McCloskey and While, Katz appears to view competence as the "potential" of a professional, but she emphasizes on the link between competence and performance for serving a cause or attaining a specific outcome which requires demonstration of one's potential using professional judgment.

On the contrary, the Quality Education Review Committee at Monash University, Australia, described competence as "the ability to use knowledge and skills effectively to achieve a purpose" (Monash University, 1998, p.3); hence, indicating that competence is inclusive of performance to achieve an end. Similarly, Worth-Butler et al. (1994) defined competence as "mastery of requirements for effective functioning in varied circumstances of the real world [involving] observable behavior which can be measured but also unobservable attributes including attitudes, values, judgmental ability and personal disposition" (pp. 226-227). In other words, these authors subsume capability and performance into competence, hence employing a broader definition of competence. This definition is congruent with Benner's (1984) position that competence is the ability to operate in the real world. Many nursing associations today define competence with a similar broadness. For instance, the College and Association of Registered Nurses of Alberta (CARNA, 2006) defined competence as "the ability of a registered nurse to integrate and apply knowledge, skills, judgment, and interpersonal attributes required to practice safely and ethically in a designated role and setting" (p. 17).

### *Competence and Competency*

Although competence and competency are interlinked, many scholars highlight that there is a distinct difference between the meanings of competence and competency. Short (1984) asserted that competence is a normative concept, but people assume it as descriptive concept. Similarly, people refer to it as "a thing or an activity," but it is "a quality or state of being" (p. 203); while a competency is a specified attribute "on which a person's adequacy or sufficiency may be judged" (p. 201). Gale and Pol (1975) argued that like intelligence, competence is a plural concept. Both terms imply a complex integration of interrelated elements. Hence, the use of the term competences or competencies is inaccurate if competencies are thought of as pieces that make up a total competence. "Therefore, it is illogical to call *intelligencies* pieces of intelligence" (p. 20). However, competence and competency may be regarded as two different concepts, but they have not always been clearly presented as such in the existing literature (McMullan et al., 2003; Zhang, Luk, Arthur, & Wong, 2001).

According to Woodruffe (1993), competence involves aspects of the job that an individual can perform, whereas competency is an individual's behavior underpinning competent performance. Similarly, a job includes a set of deliverables, outputs, or roles, each of which requires some competencies, but competencies are not aspects of the job. To elaborate, the CARNA (2005) requires that each registered nurse comply with the Canadian Nurses' Association "Code of Ethics for Registered Nurses." This is an aspect of the nurse's role. To fulfill this role, the nurse must have certain competencies, such as sensitivity towards clients and the ability to recognize his/her own values and assumptions and to maintain confidentiality of client information. Based on this perspective, competence may be viewed as a composite of competencies, which is a different interpretation than Gale and Pol's (1975) perspective of competence and competencies.

Eraut (1998) also differentiated competence from competency. Accordingly, competence has a holistic meaning, whereas competency refers to a specific capability, such as problem solving, critical thinking, patience, and so on. Therefore, Eraut prefered to use the word *capability* rather than competency, which is an underlying characteristic resulting from a combination of attributes. Similarly, Fearon (1998) referred to competency as "a performance capability needed by workers in a specific occupational area [that] may be cognitive, attitudinal, and or psychomotor" (p. 19). Khoza and Ehlers (1998) endorsed these view by defining competency as "cognitive, affective, and psychomotor abilities to perform specific tasks satisfactorily" (p. 68). Manley and Garbett (2000) noting the origin and focus of the terms, added that competence and competences are job related and involve a description of an action, behavior, or outcome that a person should demonstrate in his/her performance; whereas competency and competencies are person orientated and refer to the person's underlying characteristics and qualities that lead to effective and/or superior performance in a job. Concurrent with these views, Zhang et al. (2001) regarded competencies as sets of knowledge, skills, traits, motives, and attitudes that are required for effective performance in a wide range of nursing jobs and various clinical settings. They contend that competencies are assumed to be present when a nurse accomplishes a given task, and thus they can be derived from an analysis of the actual practice.

Based on the above descriptions, competence is an aspect of work that an individual can perform, while competency and competencies refer to individual's behavior(s) underpinning competent performance (Fearon, 1998; McMullan et al., 2003; Woodruffe, 1993). Gonczi (1994) noted that professional competence is derived from a set of relevant attributes (knowledge, skills, and attitudes) which jointly underlie competence. Therefore, a competency represents a combination of attributes that is integrated in successful professional performance. Considering this, professionals' overall competence is dependent on the level of achieving every specific competency that is expected of them. Competencies may be derived from professional standards and/or predefined expectations (Gurvis & Grey, 1995). Watson et al. (2002) explicated that, instead of specifying what a person is deemed competent to do, occupational standards denote what the public can expect from a practitioner. Usually such standards are declared by professional associations (CARNA, 2006, for example). These standards are accompanied by indicators of performance as well as the required competencies to fulfill the requirement of a nurse in Alberta.

The above discussion clearly reveals that competence is a complex concept. The difficulties involved in defining competence are related not only to various conceptualizations of the term competence but also to the use of related terms (e.g., quality, capability, and performance) that differ in their interpretation or meaning. Although variations are noted among these definitions, I agree with Campbell and Mackay's (2001) observation that three factors are common in most of the definitions: (a) they refer to the ability of the practitioner in a specific role; (b) they are an integration of various elements, knowledge, skills, attitudes, judgment, and abilities; and (c) they are influenced by the context. Moreover, competence and performance are inexorably linked because professional competence is teleological in nature (Bradshaw, 2000). In other words, competence requires the application of knowledge and skills in professional practice for a desired outcome (Beach, 2002; Waddell, 2001; While, 1994).

## What Constitutes Competence in Nursing?

While (1994) explicated the evolution of defining nursing competence. Accordingly, until the late 1970s psychomotor skills were the main focus of nursing competence. A decade later critical thinking and decision-making gained more recognition as generic skills for being professionals. And then the need for sensitivity and creativity was recognized with a conceptual shift in nursing from a biomedically driven discipline to a more socioculturally informed discipline (Meleis, 1996). Similarly, Bradshaw (2000) stated that in the previous nursing system competence meant "fitness for a specified functional outcome performance" (p. 319), but since 1979 the term competence has referred to the practitioner's psychological state of readiness or being a knowledgeable doer.

Although many nurse scholars recognize the holistic approach to conceptualizing competence, the reality of nursing practice continues to demand task accomplishment (Bradshaw, 1997; Greenwood, 2000; Watson, 2002). Hence, there is no consensus on the definition of competence (Bradshaw, 1998; Campbell & Mackay, 2001; Watson et al., 2002; Meretoja, Isoaho, et al., 2004). However, most definitions recognize that competence results from the integration of at least three elements or components: knowledge, skills, and attitude. In addition, the word *skill* is used in a wider sense and is not limited to psychomotor skills (Lindeman, 1996). However, it is worth mentioning that psychomotor skills in nursing also require certain theoretical knowledge and attitude besides the motor coordination if it is expected to be performed safely and effectively (Alavi, Loh, & Reilly, 1991; Bjork, 1999b; Bjork & Kirkevold, 1999). As indicated earlier, competence is an abstract term; individuals may define it differently based on their value of quality and expectations from nurses, and hence specific to the context. The evolution of conceptualizing competence in nursing is reflected in the following definitions:

De Back & Mentkowski (1986), stated that competence is a "broad, generic ability, characteristic of the person, that transfers across settings and situations and is not a set of discrete skills" (p.276). Furthermore, they posited that competence is developmental, and holistic in nature because it is made up of several integrated components including self perception, skills, affects, motivation and knowledge as the outcomes of educational processes. While Parry (as cited in Proehl, 2002) defined competence as "a cluster of related knowledge, attitudes, and skills that affects a major part of one's job; that correlates with the performance on the job; and that can be measured against well-accepted standards" (p. 97). These definitions indicate that competence is a composite of various elements; hence, holistic in nature. They also indicate that performance is associated with individual abilities and job performance. Although, association of competence with performance is explicit in the latter definition, it is implicit in the former definition.

Because nursing is a hybrid of practical and theoretical knowledge (Benner, 1984), competence in nursing practice requires a blend of the knowledge, skills, values, and attitudes that would enable a nurse to function as an autonomous professional (Beach, 2002; Fearon, 1998; Ovalle, 2000). Professional accountability, knowledge-based and ethical practice, safe and effective patient care, a holistic approach to care, teamwork, and lifelong learning are commonly identified standards or expectations in nursing practice (CARNA, 2005; Australian Nursing and Midwifery Council, 2002; Nursing and Midwifery Council, United Kingdom Central Council, 2002). Therefore, nurses must possess and apply certain knowledge, skills, and attitudes to fulfill these expectations.

Professional knowledge is inclusive of propositional knowledge - *knowing that* and practical or process knowledge - *knowing how* which a nurse needs to perform his/her job effectively (Beach, 2002; Eraut, 1994). Hence, "nursing knowledge has to be related to the practice of nursing and to the situation at that time" (p. 81). Although propositional knowledge is a compulsory element of nursing competence, it poses challenges in terms of assessment, especially if direct observation is used to provide evidence of competence. Polanyi (1976) contended that people's knowledge of how to act may become tacit knowledge that is not easily explained to others or even to themselves, because they spontaneously do something without conscious deliberation. People may know more than they can articulate. Hence, it is challenging to explicate what exactly makes a nurse competent in her or his professional practice (Polanyi).

Many researchers have classified the skills needed in nursing practice (Alfaro-LeFevre, 2002; Bradshaw, 1997; del Bueno, Weeks, & Brown-Stewart, 1987; Girot, 2000b; Godin, 1996; Taylor, 1995). These classifications are different but overlapping. The most commonly mentioned are cognitive/intellectual skills, interpersonal skills, and technical/manual skills. For instance, Alfaro-LeFevre (2002) explains that the effective use of the nursing process requires manual, intellectual, and interpersonal skills. She notes critical thinking, interpersonal skills and caring attitudes as the important constructs of clinical competence. Similarly, del Bueno and colleagues contended that competence in nursing has three dimensions: critical thinking, interpersonal skills, and technical skills. Bradshaw also highlighted communication, interpersonal skills, critical thinking, and analytical and problem-solving skills. In addition, Taylor proposed that current society requires of nurses' moral competency, which refers to the ability to live up to a personal moral code and role responsibilities. Some researchers inquiring into patients' perceptions of nursing care also emphasized that communication and interpersonal skills are imperative for competence in nursing practice (Fosbinder, 1994; McCabe, 2004; Shattell, 2004).

Considering various descriptions of competence, May, Edell, Butell, Doughty, and Langford (1999) maintained that competence in nursing practice entails essential, cognitive, psychomotor, and affective skills that are acquired through a process of formal knowledge and clinical experience. However, clinical decision making and critical thinking are integral parts of the process. Oermann (1997) believed that critical thinking enables the nurse to process and analyze information that is required for solving clinical problems and deciding what actions to take. Given the fact that nurses are expected to make rational decisions in caring for patients or families with complex health needs and competing economic realities, critical thinking has been accepted as one of the core competencies for effective action in professional nursing practice (Di Vito-Thomas, 2000; Maynard, 1996).

Quinn (1995) asserted that safety is a key component of competence. A nurse may not be considered competent if he/she is unable to provide safe care, but it is not the only component of competence. Similarly, Parse (2003) in her editorial "A Call for Dignity in Nursing," asserts that technical skills are not the hallmark of nursing competence. She stresses the relational ability of a nurse with others as a unique characteristic of competence in nursing. Hence, listening to and understanding the clients are viewed as important factors in nurses' competence. These examples of expected behaviors may not be achieved only through certain knowledge or skills, but also require a certain attitude.

Abruzzese (1996) described nurse's competence as a combination of correct knowledge, skills, and attitudes that produce desired outcome in nursing practice. This view of competence includes two factors: (a) what is expected of a nurse—the desired outcome, and (b) what is required to achieve the desired outcome. Hence, besides the specific professional knowledge and skills, a certain attitude as well as judgment is required to achieve the desired outcome. Quinn (1995) contended that attitude is fundamentally important for professionals, although it is difficult to explain attitude compared to practical or intellectual skills. She described attitude as a composite of three components: cognitive or belief, affective or feelings, and motor or tendency to action. In other words, one exhibits certain actions or emotions based on specific knowledge, values, and feelings. Thus two health care professionals may have different attitudes towards hand washing in spite of their knowledge of asepsis if they differ in their values of accountability for patient care.

Using a phenomenological method, Ramritu and Barnard (2001) studied the meaning of competence among new nursing graduates. They report eight conceptions of competence: "competence as safe practice; competence as limited independence; competence as utilization of resources; competence as management of time and workload; competence as ethical practice; competence as clinical skills; competence as knowledge; and competence as evolving" (p. 47). Again, most of these conceptions are in agreement with what other scholars have viewed as important in nursing practice. However, the emphasis on time management and workload is not as explicit as noted in this study. In my personal experience, the demand for time and workload management in nursing practice has always been a source of great tension between task management and holistic care. In my opinion, if time and workload management are implied in nursing competence, then it must be made explicit.

Recently, Utley-Smith (2004) surveyed 363 nurse administrators from three health care settings (i.e., hospitals, home health agencies, nursing homes) in North Carolina, USA to identify competencies needed by new baccalaureate graduates in today's health care environment. Forty-five nursing competencies were identified in the study that were grouped into six constructs using factor analysis. These constructs were: health promotion, supervision, interpersonal communication, direct patient care, computer skills, and caseload management. Utley-Smith pointed out that the importance of competencies by work setting differed significantly. It is important to note that computer skill is a comparatively recent required competency in nursing.

In view of the above discussion, it is obvious that there has been increasing efforts to define competence in nursing practice and to identify the core competencies for nursing professionals (Bradshaw, 1997; 1998; Khoza & Ehlers, 1998; O'Connor, Pearce, Smith, Vogeli, & Walton, 1999; Tzeng & Ketefian, 2003; Utley-Smith, 2004; While, 1994). Although findings of various studies differ in regards to the level of importance of a specific competency, commonalties are evident in regards to what constitutes competence in nursing. According to Ovalle (2000), two different organizations from different parts of the world, the Hong Kong Hospital Authority project and the Pew Commission in the United States used different methods to identify generic competencies for their professionals. Nevertheless, they reported some similar competencies that are in accordance with the World Health Organization Strategy (cited in Ovalle, 2000). For instance, all three include the competencies

> (a) to practice at all times in an ethical manner, (b) to promote health; (c) to provide evidence-based, systematic, and holistic care; (d) to work in partnership with multidisciplinary teams and recipients of care; and (e) to demonstrate a commitment to lifelong learning and to help others to learn. (¶ 4)

It is interesting to note that most of these competencies are already considered crucial by various professional associations around the world, as noted earlier in this chapter. Although, there is no universal agreement on the definition of competence in nursing, considerable similarities have been noted in what may constitute competence in nursing practice.

## What Factors Influence Competence?

Information in the above sections indicates that nurses' competence is influenced by various variables including individual, educational, contextual and societal factors. As noted in the previous section, competence involves two important aspects: what is expected of a nurse—the desired outcome—and what is required to achieve the desired outcome (Abruzzese, 1996) which in turn contribute to the development of competence or the actualization of competent performance. Because these factors are inextricably linked, the reader will notice that the division of these factors is fairly arbitrary.

### *What Is Expected of a Nurse?*

Several stakeholders appear to have influence on the expectations of a nurse including the health care institutions, professional organizations, educational institutions, and governments. Likewise, the personal role image of professionals and the attitude and expectation of supervisors, health care consumers, and working colleagues may influence nurses' work performance (Eraut, 1994; 1998; While, 1994). However, various professional bodies, providers of professional education, and employers are viewed as the major stakeholders who influence professional competence. Professional bodies have the authority to promote professional practice based on the ideology or conception of a profession, but they are also accountable for protecting public safety through competent professionals (Eraut, 1994; Mancino, 2005). The conceptualization or theory of a professional discipline plays an important role in determining what to expect from its professionals (Kikuchi, 2003). According to Bjørk (1999b), conceptualization of the profession should include the dimensions of skilled performance, caring intentions, and disciplined understanding, which is "knowledge that is developed within the perspective that is the ideology or belief systems of any discipline" (p. 59). Eraut (1994) described this knowledge as specialized knowledge that directs practitioners in their choice of goals and actions.

Although there is no universal consensus on the conceptualization of nursing (Gortner, 1999; Kim, 2000), professional associations and regulatory bodies in each country (such as the Canadian Nurses Association or the Royal College of Nursing) delineate the conception of the profession, the scope of practice, the role and responsibilities of professionals, and the professional standards, which informs the public on what they can expect from a practitioner (Watson et al., 2002). Moreover, professional bodies, particularly the regulatory organizations, identify policies and procedures to achieve the set standards. Standards for professional competence are inclusive of cognitive, technical, and affective aspects of practice, including nonmeasurable attributes such as attitudes, values, and disposition, which are inferred from behaviors (Ellis, 1988; Norman, 1985). Professional standards often provide guidance for curriculum design as well as serve as a useful foundation for developing institutional standards of patient care (Dozier, 1998). For instance, if client education is one of the professional standards, then educational institutions must prepare nurses for this role, and health care organizations should have policies and practices that facilitate nurses' achieving this standard, although the scope, processes, and content of education may vary from one organization to another based on various factors, including patient/client needs.

Educational institutions, whether colleges or universities, are guided by the concerned professional bodies in regards to the nature and scope of professional knowledge for nursing. Nevertheless, educational institutions and educators also influence the quality of education (Eraut, 1998) based on their personal and institutional philosophy in addition to other factors such as institutional policies and resources. Hence, colleges and nursing faculties in universities of a particular country may follow the broader instructions of their professional bodies, yet vary in their curriculum or in actualizing the curriculum. Therefore, they may differ in their expectations from graduates. For instance, nursing graduates who have been exposed to a problem-based curriculum rather than a didactic curriculum are expected to demonstrate more of these capabilities including problem-solving, critical-thinking, and self-directedness, which may ultimately have an impact on their competence in nursing.

Besides professional bodies and educational institutions, employers have an extensive influence on what is expected of nurses. Moreover, employers have direct control over the work environment of nurses, which in turn has extensive influence on the performance of nurses. Similarly, patients'/clients' health care needs as well as expectations also influence nurses' competence. Concurrent with several models of nursing performance, McCloskey and McCain (1988) noted that environmental, organizational, and human relations variables must be considered in exploring the quality of nurses' job performance. Further discussion of these variables is included under the contextual factors in this chapter.

In addition to the above, other health care professionals with whom nurses work closely, such as physicians, may also indirectly influence what is expected of nurses. According to Eraut (1994), the development of competence cannot be treated as a pure technical matter, but one has to acknowledge the social and political dimensions in constructing competence. For instance, in many countries, including Pakistan, medicine has a monopoly over health care organizations. As a result, physicians have more power than nurses when role negotiation and nurses' responsibilities in health care service organizations are involved. This monopoly not only impacts on what is expected of nurses within specific patient-care situations, but also shapes society's expectations of nurses. To elaborate, nurses may have the necessary knowledge to make some patient care decisions or advise their clients, but they may not be considered capable by their patients or may not be granted autonomy to make decisions unless they are endorsed or communicated by a physician.

## *Factors Required to Achieve the Desired Outcome*

Like the extensive list of stakeholders who may influence what is expected of a nurse, a variety of factors may also affect the desired outcome, including personal or individual, educational (curriculum and its delivery), and contextual or environmental factors.

### *Personal or Individual Factors*

Many models of competence or job effectiveness in nursing (Irvine, Sidani, & Hall, 1998; Lin & Chen, 2004; McCloskey, 1983) account for personal characteristics or capabilities of the professionals. These characteristics include a variety of psychological factors, including self-concept; motivation; emotional stability; cognitive abilities such as perception, judgment, and reasoning; and demographic factors such as, age, marital status, job position, and years of education and experience. Zhang and colleagues (2001) contended that skills, traits, motives, and attitudes all contribute to effective nursing performance. In their view, because of rapid changes in health care, nurses are required not only to possess adequate knowledge or skills for their job, but also to be able to transform competencies into effective performance in new situations, which necessitates having some underlying personal attributes such as commitment, flexibility, thoroughness, self-confidence, and motivation. In my opinion, these attributes are helpful in developing not only cognitive skills, but also interpersonal skills, which are an important aspect of nursing competence (Alfaro-LeFevre, 2002; Fosbinder, 1994). Drawing on Boyatzis' work, Zhang et al. argued that specialized professional knowledge (facts and concepts) and technical skills are important aspects of practitioners' competence, but it is the underlying attributes and personal characteristics that translate that knowledge and those skills and into effective actions that lead to excellent performance.

Beeken (1997) identified *self-concept* as the perception of self based on input from others, the environment, and the self. Self-concept has two components: self-esteem, or appraisal of self-worth; and self-image, or one's perception of the physical self. Drawing on the findings of various research studies, Beeken noted that people with low self-esteem have less tolerance for information that contradicts their self-image. Furthermore, they may feel alienated and have difficulty in decision making. To the contrary, people with high self-esteem demonstrate risk-taking behaviors, creativity, receptiveness to new experiences, and confidence in their decision-making abilities. According to Stelzer (1992), self-confidence is reflected in professionals' morale and caring actions. Arthur, Sohng, Noh, and Kim (1998) noted that older (> 35 years), married graduates and those with more than 12 years of nursing experience reported a higher professional self-concept than did their younger, unmarried, diploma-trained, and less-experienced colleagues. Similarly, self-concept may be influenced by professional autonomy. A significant relationship has been noted among autonomy and nursing education, the practice setting, the clinical specialty, the functional role, membership in professional organizations, and gender-stereotyped personality traits (Schutzenhofer & Musser, 1994). Autonomy can influence role performance through its effect on individual motivation and empowerment (Irvine, Leatt, Evans, & Baker, 1999; Sabiston & Laschinger, 1995).

According to Kikuchi and Harada (1997), professional autonomy represents the professional work abilities of nurses. Hence, professional autonomy can be viewed as an indicator of competence. In their study of predictors of professional autonomy, Kikuchi and Harada measured professional autonomy in nurses on five subscales: cognition, performance, concrete judgment, abstract judgment, and independent judgment. They reported that each of the subscale scores of professional autonomy in nurses had a significant and positive correlation with age, years of experience, work satisfaction and motivation, self-confidence, and aptitude for nursing. In an Australian study of 178 nurses, Finn (2001) found autonomy to be the most important job component of registered nurses' job satisfaction. Finn reported that on a scale of 1-7 (*very dissatisfied* to *very satisfied*), the actual level of satisfaction with autonomy was 4.6, and the mean for job satisfaction was 4.3 because nurses were discontent with the other two job components, task requirements and organizational policies. These studies further supported earlier research that indicated that professional autonomy is influenced by the personal characteristics of the nurse and the structural features of the unit, such as workload (Alexander, Weisman, & Chase, 1982).

The opportunity to practice, or experience, is found to be an important factor in developing competence or gaining expertise (Battersby & Hemmings, 1991; Benner, 1984; Clinton et al., 2005; Eraut, 1994). However, experience on its own does not result in the development of expertise. In a study of competence based on Benner's (1984) model, Garland (1996) reported that all nurses with a similar work environment and length of experience may not accomplish all aspects of transition from novice to expert at the same rate or intensity. This finding corroborates with Benner's, and Eraut's views that expertise is predicated on learning from experience so that future practice is enhanced. In other words experience needs to be processed if it is to have an impact on an individual's behavior. Schwirian (1978) found a positive relationship between academic performance and on the job performance following one to two years of practice as nurses. Her findings imply that professional competence is initiated through educational program and enhanced through formal knowledge and clinical experience. According to Doran and colleagues (2002), the length of nurses' experience in the hospital (also applicable in the community) is expected to affect their role performance. More experience generally leads to skilled performance and enhances confidence. Likewise, it provides nurses with greater opportunities to develop working relationships with physicians and other hospital staff, which in turn leads to better performance.

McCloskey & McCain (1988) reported that the amount of experience is the best predictor of performance with regard to critical care skills, but not other skills, such as leadership and planning, and evaluation ability. Later, Maynard (1996) reported that the experiential component of socialization is the key influencing factor on competence as well as critical thinking. Similarly, the role of experience in development of *clinical judgment* is highly recognized (Benner, Tanner, & Chesla, 1996b; Ferguson & Day, 2007). In a longitudinal study on "Nurses' Practical Skills Development in Clinical Setting," Bjork and Kirkevold (1999) argued the prevailing notion that repeated experience with similar situations lead to better performance. They found that nurses in their study with increasing experience were able to perform the selected practical skills (surgical wound dressing and patient postoperative ambulation) with higher flow and speed, but they repeated many of their initial mistakes.

Although it is accepted that experience provides the opportunity for the enhancement of perception through anticipation and reflections, the exact process of how experience improves competence is still being debated (Eraut, 1994; 1998). In Eraut's (1998) view, learning from experience is debatable because there is little evidence about what precisely is learned from experience and how. He explained that learning through experience "remains largely in the form of tacit knowledge, excluded from formal specifications for qualification, yet still necessary to perform on the job" (p. 131). In addition, there is "difficulty in establishing when years of experience have led to higher levels of expertise and when they have simply led to greater seniority" (p. 132). Hence, he eloquently pointed out that "learning from experience could be fallible and valuable" (p. 132).

***Educational Factors***

Because knowledge is an important component of professional competence, the importance of professional education and its impact on practice cannot be denied. Professional education in nursing includes preregistration education, continuing education, and higher education (Eraut, 1994). Eraut elaborated that professionals continuously develop their competence after the initial qualification. Moreover, the initial two to three years are considered crucial for developing a personalized pattern of practice in accordance with the professional requirements.

As stated earlier, although there is increasing advocacy by nursing organizations for a baccalaureate degree to be the minimum entry requirement for nurses to begin professional practice, actualization of this goals has been faced with multiple challenges (Beach, 2002; Gould, 1999; Nichols & Chitty, 2005; Ross-Kerr, 1999). Extensive research has been done over the past 30 years, especially in North America and United Kingdom, to explore the impact of educational programs on nurses' job effectiveness, performance, and clinical competence. However, the findings of these studies are not consistent (Bartlett et al., 2000; Boggs et al., 1987; Bullough & Sparks, 1975; Clinton et al., 2005; DeBack & Mentkowski, 1986; Gray et al., 1977; Joyce-Nagata et al., 1989)

McCloskey (1981) studied the effectiveness of nursing education on job effectiveness. She compared nurses with diplomas, associate degrees (ADs), and baccalaureate degrees (BScN) in nursing. In view of her findings, McCloskey concluded that the total number of years of nursing education has a small but significant effect on job performance. DeBack & Mentkowski (1986) compared the competence of nurses with varying educational backgrounds in hospital and community settings and found that nurses with BScN degrees demonstrated more competencies than those with associate degree or diploma education. For instance, nurses with BScN degrees frequently demonstrated teaching-coaching behavior and a more influencing technique in their instruction to encourage learning. Hence, these researchers concluded that higher education promotes a broader range of abilities than does experience.

McCloskey & McCain (1988) studied a number of variables (e.g., education, workload, career commitment) and their impact on various aspects of nursing performance, such as teaching, planning and evaluation, communication, and professional development. In view of their findings, the researchers concluded that although education is one of the determinants of job performance, it has a variable effect on different aspects of the job, such as critical care skills verses leadership, or planning and evaluation skills. In a Australian based study, Cruickshank, MacKay, Matsuno, and Williams (1994) found that although both clinical experience and education had a significant effect on competence independently, there was no interaction between these variables on increasing competence.

Johnson (1988) did a meta-analysis of 139 studies that aimed to determine the difference in performance of nurses with different educational backgrounds. The author indicated significant differences between BScN, diploma, and associate-degree nurses.

Accordingly, BScN nurses had more knowledge and communication and problem-solving skills. Beeken (1997) studied the relationship between critical thinking and self-concept and reported a higher level of critical thinking and professional self-concept among staff nurses with baccalaureate degrees than those with diplomas and associate degrees. The relationship between higher education and critical thinking was statistically significant. Similarly, a significant relationship has been found between education and communication skills, professional self-concept, and professional autonomy (Arthur, Sohng, Noh, & Kim, 1998; Doran et al., 2002; Kikuchi & Harada, 1997; Schutzenhofer & Musser, 1994). More recently, Aiken and colleagues (2003) established that nurses' level of education has a direct impact on patient outcome. Accordingly, a 10% increase in the number of nurses holding a baccalaureate degree was associated with a 5% decrease in both the likelihood of patients dying within 30 days of admission and the odds of failure to rescue patients who developed complications because of surgery.

As indicated earlier, professionals continuously need to learn on the job in order to keep their knowledge current and to enhance the quality or scope of their performance. Eraut (1994) discussed three sources of learning on the job: publication in a variety of media, practical experience, and people. For instance, in terms of people, there may be specific mentors who could suggest objectives, advise on sources of information, challenge interpretations, and provide feedback. Likewise, co-workers and colleagues may also share their perspectives and findings. The availability and quality of these variables are known to influence nurses' performance, especially that of new graduates (McCloskey & McCain, 1988; Wood, 1998).

According to Eraut (1994), many institutions offer some form of *continuing professional education* (CPE) opportunities for their professional workers. CPE usually refers to formally organized conferences, courses, or educational events rather than work-based learning; whereas *continuing professional development* (CPD) entails both. Most professional codes of conduct refer to an obligation to engage in CPD, and some professional organizations require mandatory continuing education credits for the renewal of a license to practice (Nichols & Chitty, 2005). However, the role of CPE in substituting for work-based learning has not always been clearly delineated (Eraut, 1994; 1998; Wood, 1998). Through a literature review, Wood explored the effects of CPE on clinical practice. She identified two factors that make it difficult to determine the direct bearing of CPE in improving practice: the web of variables that are involved in determining performance and are difficult to disentangle, and measurement of some abstract skills, such as effective communication. Nevertheless, without making a conclusive assertion, Wood acknowledged that CPE seems to have an impact on the personal and professional development of practitioners, which in turn could affect the patient care quality. At the individual level, CPE is reported to improve knowledge, self-confidence, self-awareness, and awareness of professional issues; whereas at the practice level, CPE is reported to improve communication skills and work organization and management and to enhance individualized care and research-centered practice.

Considering the above information, it is not difficult to understand that education, both preregistration and continuous, including formal and informal, influences professional competence, but the extent of that influence is difficult to measure. Nurses' caring behaviors may be developed and polished by their educational processes. However, characteristics of work environment may facilitate or inhibit these behaviors affecting nurses as well as their client satisfaction (Ervin, 2006).

### *Contextual or Environmental Factors*

Apart from educational preparation, context plays a major role in the development as well as actualization of competence. As noted earlier, the attribution of competence involves judgment of quality, and the acceptable standards of competence may vary from one context to another. Context involves various philosophical, historical, sociocultural, political, and financial characteristics at the macro and micro levels. For instance, within the macro context, or at the broader level, nurses' behavior is influenced by societal expectations and valuing of the profession (Garland, 1996); whereas an array of factors may influence nurses' behavior in their specific work environment, or within the micro context (Lin & Chen, 2004; Meretoja, Leino-Kilpi, & Kaira, 2004). The work environment entails many factors that may impact the competence of nurses, such as workload and availability of time for patient interaction; patient variables, acuity, and dependency; area of work (medical-surgical versus specialty areas); resources (such as equipment and supplies); quality of collegial and supervisory support, institutional policies, and practices; and so on. Considering the potential power of contextual factors at the micro level, many nursing researchers have focused on exploring the relationship between these factors that influence nursing performance and its outcome, as discussed below.

Professional autonomy, control over practice, staffing levels, and nurse-physician relationships are some of the important variables in the work environment that are related to nurses' job satisfaction, their work performance, and patient outcomes (Aiken et al., 2001; Foley, Kee, Minick, Harvey, & Jennings, 2002; Kikuchi & Harada, 1997; Krugman & Preheim, 1999; Vahey, Aiken, Sloane, Clarke, & Vargas, 2004). According to McCloskey and McCain (1988), job satisfaction and feedback from supervisors are determinants of job performance. Aiken and Sloane (1997) reported better patient outcomes when nurse autonomy, control, and status were enhanced and good relations with physicians existed. Similarly, Baggs, Ryan, Phelps, Richeson, and Johnson (1999) identified an association between nurse-physician collaboration and improved outcomes in high-risk complex patients in three intensive care units. Carlowe (1998) noted that a supportive work environment and nurses' autonomy was not only beneficial for nurses, but it also benefited patients when they were cared by nurses who were not burned out. Based on a comprehensive research data involving 43,000 nurses from more than 700 hospitals in the United States, Canada, England, Scotland, and Germany in 1998-1999, Aiken and colleagues (2001) reported that emotionally exhausted nurses have a negative impact on the quality of patient care and patient outcomes.

Using a nursing role effectiveness model, Doran and associates (2002) demonstrated that various structural variables influence nurses' role performance (independent and interdependent), which in turn affect patient outcomes. Their study consisted of data from 372 patients and 254 nurses from 26 general medical-surgical units in a tertiary care hospital. Patient structural variables included medical diagnosis, age, gender, and education. Nurse structural variables included educational preparation and length of hospital experience. The unit structural variables included the adequacy of time to provide care, work autonomy, and role tension. Work autonomy in this study referred to "the characteristics of job that foster increased feelings of personal responsibility for the work outcome" (p. 31). The findings of the study indicate that work autonomy (although unexpectedly) and role tension had a negative influence, whereas adequate time to provide care was positively related to nurses' performance. Work autonomy and the educational preparation of nurses had a positive effect on nurses' communication and coordination of care. However, it is interesting to note that nurses' length of experience had a negative impact on their communication, but a positive impact on their coordination of care.

Extensive evidence suggests that the type and level of nursing staff affects the quality of care and patient outcomes, including the length of stay and mortality (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Aiken et al., 2003; McCloskey, 1998; Shortell et al., 1994). High workload associated with staffing shortage leads to unfinished work, stress, and high chances of errors (Shortell et al.). Roseman and Booker (1995) reported an inverse relationship between medication errors and nurses' workload. McCloskey described the relationship among six adverse patient outcomes (medication errors, patient falls, urinary and respiratory tract infections, skin breakdown, patient complaints, and mortality), the total hours of nursing care, and the proportion of those hours of care delivered by registered nurses. Using multivariate analyses, she used records of various units from large university hospitals in America to determine correlations among staffing variables and patient outcomes, as stated above.

McCloskey reported an inverse relationship between the number of registered-nurse hours of care and the rates of medication errors, decubiti, and patient complaints. Likewise, Sovie and Jawad (2001) studied 28 university hospitals and found that patient falls increased as nurse-patient ratios increased, whereas patient satisfaction with pain control decreased as nurse-patient ratios increased. In their study of 168 Pennsylvania hospitals, Akin and colleagues (2002) found that each additional patient added to the average workload of registered nurses increased the risk of death by 7% following common surgical procedures. Their results indicate that the risk of death was more than 30% higher in hospitals where nurses' mean workloads were eight patients or more per shift, compared with those nurses who cared for four or fewer patients (Aiken et al., 2002).

Many researchers inquired whether the type of nursing delivery model, such as primary nursing, has a direct impact on nurses' performance and patient outcome (Drach-Zahavy, 2004; Sellick, Russell, & Beckmann, 1983). Although, Sellick and colleagues provided some evidence to support this hypothesis, a significant relation could not be established. In Israel, in a recent study of 368 nurses from a variety of hospital units, Drach-Zahavy found that primary nursing did not have a direct impact on nurses' performance, but rather an indirect effect through the interaction of nurses with their supervisor during primary nursing. She reported, "If supervisor support was high, performance was substantially higher than if supervisor support was low" (p. 7).

Other studies also indicated the impact of supervisors' (head nurse or managers) communication, goal setting, and feedback on staff performance (McCloskey & McCain, 1988; Meretoja & Leino-Kilpi, 2003; Stull, 1986). McCloskey and McCain noted that the top performers had significantly more feedback from supervisors than the poor performers did. Using two different study populations, AbuAlRub (2004; 2006) investigated the effect of job-related stress on job performance among hospital nurses and analyzed the effect of social support from coworkers on the stress-performance relationship. This researcher concluded that an enhanced level of social support in the work environment may not only help to overcome the prevalent issue of staff retention, but reduce job related stress and hence improve the quality of patient care. These findings indicate that supervisors' expectations and communications, as well as emotional support from peers and supervisors, influence nurses' performance.

The positive effects of emotional support on the performance of neophyte nurses are also documented in the literature. Brasler (1993) conducted a study to determine the variables predicting clinical performance among new graduate nurses. The study included six preceptor orientation programs offered by hospitals in the Baltimore and Washington. The researcher reported that emotional support provided by the preceptor and the preceptor's teaching and nursing skills were the high predictors of performance in the new graduates. Other researchers (Boyle, Popkess-Vawter, & Taunton, 1996) have also reported the contribution of positive precepting experiences and support systems in the work environment for successful socialization and performance among the new graduates.

Institutional context and interpersonal dynamics among staff are also well known for their effect on the process of role transition from a graduate to a staff nurse and hence the ability of a graduate nurse to perform in the nursing workforce (Boyle et al., 1996;

Casey, Fink, Krugman, & Propst, 2004; Godinez, Schweiger, Gruver, & Ryan, 1999; Ross & Clifford, 2002; Speedling, Ahmadi, & Kuhn-Weissman, 1981). Horsburgh (1989) maintained that usually the rhetoric and practice of schools of nursing is different from the rhetoric and practice of nursing in service settings. Therefore, graduate nurses experience stress during their transitioning from student to practicing professional nurse. New graduates move from a familiar educational environment into the workforce, where expectations are to rapidly function as a competent nurse. However, nursing is an applied science; competence cannot be fully developed in classroom or clinical laboratory without experience (Saylor, 1990). Benner's (1984) work of nursing proficiency, that is, novice to expert clearly explicates that a certain level of experience is necessary for a novice nurse to be able to practice competently.

Various studies on transitioning from new graduate to practicing professional nurse (Casey et al., 2004; Ferguson, 2006; McKenna, Smith, Poole, & Coverdale, 2003; Oermann & Moffitt-Wolf, 1997; Ross & Clifford, 2002; Whitehead, 2001) indicated that the initial 6-12 month of employment is the most difficult role adjustment time period for graduate nurses, as they do not feel skilled, comfortable, and confident for as long as 1 year after being hired. Hence, the process of role adjustment from graduate to competent nurse takes at least one year. Research in this area indicated that perceived lack of knowledge and social support were the major causes of anxiety among staff nurses during their transition period (Ross & Clifford; Whitehead; McKenna et al.). In addition, Speedling et al. (1981) and Duchscher (2001) reported that an undesirable nurse-physician relationship was a significant contributory factor in the anxiety of new nurses who participated in their research.

A study (n=35) was undertaken by Oermann and Moffitt-Wolf (1997) to assess the stresses, challenges, and threats experienced by new graduates during their initial orientation and to examine the relationship of social support to these stresses, challenges, and threats. A moderate degree of stress was reported in the study, although social support scores of the new graduates indicated that most of them had an adequate support system. The predominant stresses among new graduates of this study in rank order were lack of experience as a nurse, interactions with physicians, lack of organizational skills, and new situations and procedures. Half of the new graduates (n =18) identified their challenges as new clinical experiences, such as techniques and procedures, learning to set priorities, adapting to the graduate nurse role, and interacting with physicians. Various other studies about the transition of nursing student to staff nurse report similar stressors with varied intensities (Casey et al., 2004; Cassells, Redman, & Jackson, 1986; Jasper, 1996; Kramer, 1974). Hence, these researchers highlighted a need for support during the transition phase of new graduates and emphasized the importance of orientation and mentorship programs to facilitate development of competence and successful entry into practice.

To sum up, nurses' competence is influenced by what is expected of nurses in a particular society including their macro and micro context as well as a variety of personal, educational, and contextual factors that are difficult to disentangle. Factors such as workload may have a direct impact on the level of performance; whereas other factors such as self-concept may have an indirect impact on job performance. Similarly, it is difficult to identify the extent and direction of each influencing factor. For instance, to what level is competence affected by education versus experience, and does better self-concept lead to professional autonomy, or vice versa? Considering the complex interaction of many variables that influences or contributes to the development of competence in a holistic sense, the issues of assessing competence is not difficult to imagine.

## Assessment of Competence

Assessment or evaluation of nurses' competence is an important accountability process for both nurse administrators and educators because it may be used to assess nurses' performance and their individual need for professional development, salary, or promotion decisions (Waddell, 2001); to gauge the quality of patient care (Bradshaw, 2000; Meretoja, Leino-Kilpi, et al., 2004); to identify needs for curriculum changes and improvement; or to evaluate the outcome of an educational program (Bartlett et al., 2000; Clinton et al., 2005; DeBack & Mentkowski, 1986; Howard, Hubelbank, & Moore, 1989; Kapborg & Fischbein, 2002; Manley & Garbett, 2000; McCloskey, 1983).

Although assessment, measurement, testing, and evaluation are related concepts and are used interchangeably in the literature, subtle differences should be clarified in their meaning to avoid any confusion. Evaluation is "a process of valuing or judging" while assessment refers to "estimation or evaluation; or means of evaluation." (Oxford English Dictionary, 2005). Measurement refers to the assignment of numbers to objects, events, or situations based on certain rules (Burns & Grove, 1997; Stevens, 1946). On the scales of measurement, numbers may be representative of kind or amount of attributes or characteristics possessed by those objects, subjects or events. Hence, measurement is a descriptive process which involves data collection and its quantification, whether on a qualitative or quantitative scale to identify the extent or degree of achievement (Matuscak, 1983; Waltz et al., 1991) .Testing usually refers to means of measurement using standardized test (Waltz et al.). While evaluation "involves assessing behavior through exercising judgment" (Matuscak, p. 87). In other words, measurement and testing are part of evaluation, hence evaluation can be done without measurement, but measurement without evaluation is meaningless (Waltz et al.).

McCloskey (1981) noted that performance or competence on the job could be rated based on a specific competency statement or the dimensions of performance. Similarly, certain aspects of performance could be tested using standardized tests such as those that measure critical thinking, problem solving, and/or decision making. Because tests are "carried out in a consistent and controlled manner across a wide variety of situations and subjects" (Waltz et al., 1991, p. 257), they are not context specific, and the type of measurement chosen would depend on the purpose of the evaluation. Performance may be evaluated and measured by employing various methods of data collection such as observations, interviews, review of records, such as portfolio or employee appraisals, or completion of a questionnaire. Evaluation of performance may be done through self, supervisor, or peer ratings that are usually context specific. Each approach has strengths and weaknesses which has implications upon how the outcomes of the assessments should be considered (Redfern, Norman, Calman, Watson, & Murrells, 2002; Watson et al., 2002). For instance, subjectivity and response bias are viewed as the limitations of a self-assessment approach, but it is considered an important part of a comprehensive competence assessment by many researchers (Meretoja & Leino-Kilpi, 2003; O'Connor et al., 2001; Tzeng, 2004). To elaborate, assessment of competence from the employer/supervisor perspective can reveal how the graduates are performing based on supervisors' expectations, but graduates are in a position to highlight why they are doing what they are doing.

Waltz and colleagues (1991) maintained that measurement involves making decisions at four points: conceptualization of the construct to be measured, selection of a measurement paradigm, identification of measuring instruments, and interpretation of the measurement data. It is important to note that these decisions are not necessarily linear in sequence.

### *Conceptualization of the Construct*

As noted earlier in this chapter, many definitions of *competence* have been discussed in the literature. However, these definitions are not operational (Waddell, 2001), but rather theoretical definitions or conceptual models of competence and performance. An operational definition of concept incorporates the methods or *operations* that the researcher will perform to collect data (Brink & Wood, 2001; Polit et al., 2001; Waltz et al., 1991). Operational definitions are usually specific to the setting or context in which the phenomenon or concept is being researched (Morse, 2000). Waddell pointed out, "When a definition is context specific, it is difficult to generate a definition that applies to all nurses across the span of their career" (p. 103). Although operational definitions are a requirement for a quantitative approach; priori definitions are not desirable for a qualitative approach, in which the researcher seeks to explore and/or understand the meaning of the concept from the perspective of the participants (Polit et al., 2001), which was the intent of the current study.

As noted earlier in this chapter, there are different ways of conceptualizing competence (Gonczi, 1994; Short, 1984), such as the task-based or behaviorist approach, the generic competencies or skills approach, and a holistic approach. However, each approach is constrained to some degree in terms of its assessment. Although the first approach may be commonly used, the direct observation and measurement of performance are themselves problematic because they involve judgment on the part of the observer. With the second approach, there is no guarantee that generic transferable competencies exist or are sufficient for every situation. The holistic approach is considered more credible because it addresses some of the criticism of the first two approaches (Gonczi, 1994; Manley & Garbett, 2000; McMullan et al., 2003; Watson et al., 2002). Nevertheless, the holistic approach is challenged with the issue of measurement because it is difficult to observe the psychological construct directly; rather, one has to infer competence through performance (Girot, 1993b; While, 1994; Redfern et al., 2002). Because competence is an abstract concept, it cannot be measured directly, but it can be measured indirectly through its characteristics or attributes that represent the phenomenon (Burns & Grove, 1997). Hence, competencies may serve as constructs to evaluate and measure competence (Clinton et al., 2005). Therefore competencies can be "defined in behavioral terms and inferred from the description of the effective and ineffective behaviors performed by the professionals" (DeBack & Mentkowski, 1986, p. 276). How one conceptualizes the concept of competence certainly relates to what will be measured, how it can be measured, and from whose perspective it can be measured.

### *Selection of a Measurement Paradigm*

One may choose a quantitative or a qualitative approach to measure a phenomenon of interest. These paradigms differ in their philosophical assumptions, and a detailed discussion of them is beyond the scope of this chapter. Here it is sufficient to state that a quantitative paradigm focuses on searching for facts and the causes of human behavior and emphasizes objective, observable, and quantifiable data; whereas a qualitative paradigm focuses on the discovery, description, and understanding of phenomena and thus requires the researcher's immersion in the field and interaction with those being researched in an attempt to interpret the phenomena from their perspectives(Streubert-Speziale & Carpenter, 2003). Hence, a qualitative paradigm is considered more appropriate when the phenomena under consideration "have not been studied before or have not been studied in that particular population" (Brink & Wood, 2001, p. 12). As indicated earlier, a quantitative approach will require operationalization of the concept to be studied, such as competence, which requires the researcher defining each attribute that represents competence (Burns & Grove, 1997; Waltz et al., 1991). On the contrary, in qualitative approach such information will be gathered from the participants' perspectives.

Bartlett and colleagues (2000) indicated that there is no agreement on which approach, quantitative and qualitative, is better for measuring competence. They noted that a multimethod approach has become popular because both approaches have some limitations. Considering the complexity and abstractness of competence, using mixed methods and triangulation of the data may enhance researchers' confidence in their results. As Burns and Grove (1997) suggested, "Rarely, if ever, can a single measurement strategy completely measure all aspects of an abstract concept" (p. 320).

The existing literature on measuring competence as an outcome of nursing programs shows that a variety of methods have been employed for this purpose. Many researchers have used rating scales that involve the completion of questionnaires by an assessor and/or the assessed (Battersby & Hemmings, 1991; Clinton et al., 2005; McCloskey, 1983; Meretoja & Leino-Kilpi, 2003; Ryan & Hodson, 1992; Schwirian, 1978). Alternatively, some researchers have used tests that involve a paper-and-pencil test such as problem solving (Gray et al., 1977) and the Objective Structures Clinical Examination (OSCE) (Ross et al., 1988) to measure performance on different dimensions such as technical skills, teaching, and leadership abilities. Waters and associates (1972) added an observational component to their research besides interviewing nurses and their supervisors.

Howard, Hubelbank, and Moore (1989) used the focus-group approach to evaluate graduate nurses' performance from their employer perspectives. Discussion in the focus group was based on the program's terminal objectives rather than the characteristics of individual graduates. Hence, data were collected regarding the quality of the program and the comparative performances of graduates and nongraduate nurses. Burke and Harris (2000) also used a qualitative approach to seek employers' and contractors' views about the move towards all nurses having an undergraduate degree in UK through interviews and document analysis. Yet other researchers (Bartlett et al., 2000; DeBack & Mentkowski, 1986) have used mixed methods or triangulation of data to measure graduates' competence.

The changing approach towards evaluating competence revealed in the above studies is pertinent to evaluation research or program evaluation that has evolved over the years (Rossi, Lipsey, & Freeman, 2004; Swanson & Chapman, 1994). Guba and Lincoln (1989) noted four generations of evaluation. The first generation focused measurement via tests. The second generation aimed at describing individuals, groups, or the program in light of objectives stated in behavioral terms. In the third generation the focus changed from description to judgment of merits on the basis of standards and models. And, finally, the focus of the fourth generation is responsiveness, in which the role of the evaluator is to seek out claims, concerns, and issues of outcomes from the stakeholders' perspectives. Concurrent with this approach to evaluation, the selection of few variables and the preselection of methods and instrument may not be able to fulfill the aim of such inquiry through a quantitative research paradigm but may require a qualitative paradigm because of its acceptance of multiple realities in its naturalistic environment (Swanson & Chapman, 1994; Gillis & Jacson, 2002).

### *Identification or Selection of the Measurement Tools*

The selection of tools requires the availability of valid and reliable tools. *Validity* of the tool means that it actually measures what it is intended to measure, whereas *reliability* refers to the extent to which the tool will yield consistent results if used repeatedly (Gibbon, 1995). However, various reviews on the assessment of competence (Girot, 1993b; Redfern et al., 2002) and existing tools to measure nurses' clinical competence or performance (Meretoja & Leino-Kilpi, 2001; Robb et al., 2002) have indicated a lack of valid and reliable tools, with some exceptions. For instance, the Six-Dimension Scale of Nursing Performance (6D Scale) (Schwirian, 1978) is one of the few scales that has been extensively tested for validity and reliability (Bartlett et al., 2000; Battersby & Hemmings, 1991; Gardner, 1992; McCloskey & McCain, 1988). However, Robb and colleagues noted that in spite of extensive research over more than four decades, no instrument has been found that is universally acceptable in measuring clinical competence.

Because the meaning of competence is usually negotiated by its stakeholders in a specific context, the identification of valid tools to measure competence involves a series of steps. The first step is to identify the characteristics or attributes that represent competence from the stakeholders' perspectives. In developed countries, standards of practice provided by professional associations usually accompany competency and measurement indicators to represent professional competence. Many nurse researchers who have studied competence, such as (O'Connor et al., 1999; Battersby & Hemmings, 1991), have taken such competencies into consideration first and then developed tools for measuring competence. Alternatively, other researchers have conducted descriptive exploratory research using qualitative approaches to identify the meaning of competence (Girot, 1993a; Ramritu & Barnard, 2001) or the elements and characteristics of competence from stakeholders' perspectives (Benner & Benner, 1979; Buller & Butterworth, 2001; Godin, 1996; Khoza & Ehlers, 1998; Liu, 2004; Meretoja, Eriksson, & Leino-Kilpi, 2002; Zhang et al., 2001; Schwirian, 1978).

Meretoja and Leino-Kilpi (2001) observed that all of the existing instruments have different definitions for the categories or competencies that comprise nurse competence. My analysis of various tools indicates that the domains or categories of competence and its representative behaviors have not changed much from one tool to another, but different authors have organized and/or stated them differently. For instance, Manuel and Sorensen (1995) grouped leadership skills, critical thinking, delegation and supervision, and communication under organization skills; whereas Ryan and Hodson, (1992) listed delegation and organization skills under leadership. Similarly, both the 6D scale and a tool developed by Meretoja, Isoaho, et al. (2004) include item(s) on emotional support to patients and their families, but they differ in their wordings.

Considering the inherent complexities of competence, as already discussed, the above mentioned findings are not surprising. As a result, the lack of valid and reliable tools to measure competence requires no further explanation. Measurement tools are necessary when a quantitative approach is taken to evaluate competence, but not when competence is measured qualitatively because the major goal of the qualitative approach is "to document and interpret as fully as possible the whole of what is being measured from the frame of reference of the subjects involved" (Waltz et al., 1991, p.8).

## Interpretation of the Data

This category of decisions relates to the interpretation of meaning obtained through measurement (Waddell, 2001; Waltz, 1991). One may consider norm-referenced or criterion-referenced measurement. This is a philosophical decision, which in practice is taken before the instrument is selected or the data are collected. Although in this study, the researcher did not make this decision before data collection, certain questions in the interviews (see Appendix F) were aimed to inquire as to what extent the BScN graduates are able to perform what is expected of them in their work environment. Similarly, all participants were asked describe "a successful nurses" and identify the characteristics of competence or effective performance in order to understand what constitute competence in the context of this study.

## Summary

In view of the above literature, it is apparent that generally, competence is a broad complex, and an evolving concept. Hence, the variations in the definition of competence and associated interpretations are not surprising. Consequently, competence can be conceptualized in different ways from the narrowest perspectives of completing lists of tasks to the broadest perspectives involving integration and application of knowledge, skills, and attitudes appropriate for the professional service. Following the broader definition of competence that recognizes the relationship of competence with context, it will always be necessary to clarify the meaning of competence among the stakeholders. Likewise, from the broader perspective of competence, it cannot be measured directly, but can be measured indirectly through its characteristics or attributes that represent the phenomenon as perceived by its stakeholders. Considering the inability of precision when indirect measures of assessment are employed, multiple measures rather than a single strategy of data collection are necessary. Hence, these factors were considered in the design of current study.

Given the fact that this study is of descriptive exploratory nature where no previous research exists to explain how BScN graduates describe and demonstrate their competence in the workforce in Pakistan, a qualitative approach employing multiple strategies of data collection was considered appropriate. Because I was interested in discovering what the stakeholders say and do, a quantitative approach to this study would have led to a limited view with only partial understanding. I am convinced that an important topic such as professional competence that has multiple implications for the profession not only at the institutional level (AKU), but also at the national level deserves an in-depth inquiry using a comprehensive approach. Hence, a qualitative inquiry-focused ethnography was undertaken. Ethnographic inquiry was selected because it entails a holistic approach with an effort to understand the world view of those under study (Morse, 1992).

# CHAPTER THREE:
# RESEARCH METHOD AND DESIGN

This chapter provides an overview of the research method and design employed in the study. It is divided into six sections. Section 1 begins with a rationalization of the suitability of the method for the proposed study, followed by assumptions of the study. Section 2 provides an overview of the ethnographic method and the differentiation between traditional ethnography and applied ethnography; that is, focused ethnography. Section 3 identifies the setting, population, and sample of the study, including the process of recruiting the participants. Section 4 describes the strategies and procedures of the data collection, including semistructured interviews, participant observation, and the review of documents pertinent to the phenomenon under study. This section also discusses the purposes and processes of writing a field journal and memos. Section 5 focuses on the nature and process of data analysis and identifies the measure of rigor of the study. The final section of this chapter delineates the ethical issues and the strategies that I used to prevent or minimize those issues.

Experienced researchers have suggested that the choice of research method should be driven by the nature of the research question, the level of existing knowledge about the phenomena under consideration, and the feasibility of research (Brink & Wood, 2001; Morse & Field, 1995). The goal of my study was to explore how nurses from a four-year BScN program (hereafter referred to as BScN) viewed their competence based on their personal experience and how others perceived their competence; specifically, their supervisors in the nursing workforce at Aga Khan University (AKU). For the purpose of this study, I conceptualized competence in a holistic sense, inclusive of knowledge, skills, attitudes, performances, and levels of expected sufficiency in the given context (Short, 1984; Worth-Butler et al., 1994). Because this is the first study of its nature within the context of AKU, I considered a qualitative approach appropriate for an exploration of the context-bound phenomenon of nurses' competence. Unlike a quantitative paradigm in which the researcher is bound to preselected variables, a qualitative paradigm stresses the importance of context and the participants' frame of reference (Creswell, 1994; 1998). Within the qualitative paradigm, I used a focused-ethnography method study because the focus of my research was on how four-year BScN graduates described and demonstrated their competence in the context of their work setting (AKU). I briefly considered using either grounded theory or phenomenological methods, but found them inappropriate because the study was not focusing on the process of competence development or on the individual meaning of competence.

## Assumptions of the Study

Concurrent with a humanistic constructivist approach, the following assumptions underpinned this study:

1. Knowledge is not a single and static reality; rather, it is evolving, and multiple realities or truths exist.
2. Human beings influence each other when they interact in one another's immediate physical presence; hence, knowledge is constructed through mutual understanding between the participants and the researcher.
3. Objectivity plays an important role in knowledge development; however, both theory and observations are value laden and not theory neutral.
4. Reality is context dependent because it is constructed through the blending of social/scientific knowledge and human experience.

## Overview of the Method: Ethnography

The term *ethnography* is a composite of *ethno*—folk—and *graphy*—description (Boyle, 1994), but there is no standard interpretation of ethnography. Thus the term may be used to denote a research process—ethnography as a method—or it may be used to identify a product—ethnography as a written account of a research project (Boyle, Rop[illegible] & Shapira, 2000). In the current study I used ethnography as a method of inquiry or methodology.

Initially, anthropologists used ethnography to study primitive culture, but many social and human scientists, including nurses who subscribe to the humanistic paradigm, are currently conducting ethnographies to examine subcultures within urban society and to study institutional settings (Field, 1983; Morse & Richards, 2002; Roper & Shapira, 2000; Streubert-Speziale & Carpenter, 2003). Hence, considerable diversity has been noted in the prescription and practices of ethnography (Boyle, 1994; Brink & Edgecombe, 2003; Hammersley & Atkinson, 1995). Morse (1992) explained ethnography as a qualitative research method used to "describe a culture group or to describe a phenomenon associated with a cultural group" (p. 141). Because "ethnography is a systematic attempt to discover the knowledge a group of people have, and are using, to organize their behavior" (Field, 1983, p.3), it can be used as a framework for studying the meanings, patterns, and experiences of a defined culture or group in a holistic fashion (Hammersley & Atkinson; Polit et al., 2001). In this study graduates of the BScN program at AKU-SON were the focus.

Ethnography helps to discover tacit knowledge of a cultural or social group that is usually embedded in their values, beliefs, and practices (Morse & Richards, 2002). In other words, ethnography is concerned with understanding human actions and behaviour from the emic point of view. Boyle (1994) referred to *emic* as "the insider's view, the informants' perspective of reality" and to *etic* as "the outsider's framework, the researcher's abstractions, or the scientific explanation of reality" (p. 166). Dreher (as cited in Morse, 1994b) clarified that, in terms of data, emic refers to "what people say" and etic to "what people do" (p. 158). To elaborate, Dreher (1994) noted that emic is information that is "derived from the informants and addresses the 'meaning' that informants ascribe to phenomena," whereas etic refers to the information "derived from the observations of the investigators that describe[s] the actual 'behavior' associated with phenomena" (p. 290).

The above descriptions of emic and etic are aligned with the conceptualization of culture in which emic focuses on the cognitive aspects (ideas, beliefs, and knowledge) and etic focuses on the behavioural aspects (observed pattern of behaviours) of a culture (Roper & Shapira, 2000). Regardless of the differences in their definitions, both Boyle (1994) and Dreher (as cited in Morse, 1994b) maintained that, although emic perspectives might not always conform to an etic viewpoint, both views are important in enabling an ethnographer to understand why members of that particular group do what they do. Such understanding is crucial to help the ethnographer reach conceptual or theoretical interpretations. Concurrent with these views, Hammersley and Atkinson (1995) explained that ethnography involves a participant's "watching what happens, listening to what is said, asking questions" (p. 1) for an extended period of time, and then collecting whatever data are available to clarify or elaborate on the issue under study. An ethnographer relies on various data sources, primarily participant observation and interviews, but also relevant documents and other physical evidence called *artifacts* (Agar, 1980; Roper & Shapira, 2000; Streubert-Speziale & Carpenter, 2003).

Based on the above descriptions of emic and etic in regards to conceptualization of culture, the terms *emic and etic* may be used in association with the researcher's orientation (Streubert-Speziale & Carpenter, 2003). To elaborate, if an ethnographer studied the culture of perioperative nurses and had no perioperative nursing experience, that researcher's interpretation would be from an etic perspective, while a nurse working in the Operating Room studying perioperative nurses will be from an emic or insider perspective. Aamodt indicates that an ethnographer doing research in his or her own society could not claim the role of a privileged stranger but it is also a mistake to assume that one will be considered a native (cited in Field, 1991). Therefore, the extent to which one is an insider or outsider will vary for an ethnographer based on one's multiple identities, such as nationality, occupation, gender as well the researcher's exposure to a specific setting. Considering this, my status as a researcher in this study was somewhat of an insider. All of my key informants were nurses who had worked or were working at Aga Khan University. Similarly, I had worked at Aga Khan University Hospital (AKUH) as a nurse manager 13 years ago, and I am still affiliated with AKU-SON as a faculty member, though I have been on study leave for the past three years.

### *Traditional Versus Applied Ethnography*

Fetterman (1989) differentiated between *traditional* or *classical* ethnography and *applied* ethnographic research. He explained that traditional ethnography is lengthy and time consuming and often has few policy implications or little practical significance, but applied ethnography can be conducted in a comparatively short period for a specific issue. Therefore, the applied approach, which answers specific questions, is more likely to produce implications for change and to have practical significance. Because of the specific topic and focus, applied ethnographies may be referred to as *focused*, *mini*, or *micro* and may be conducted in a hospital unit, nursing home, or social unit such as a patient-support group (Boyle, 1994; Morse & Richards, 2002; Streubert-Speziale & Carpenter, 2003).

Muecke (1994) stated that "focused ethnographies are time limited exploratory studies . . . . They gather data primarily through selected episodes of participant observation, combined with unstructured and structured interviews" (p. 199). In addition, focused ethnography relies on a limited numbers of key informants, participants "with a store of knowledge and experience relative to the . . . phenomenon of study" (p. 199). Although focused ethnographies are context bound and the participants are linked, the site of the study may be a clinic, office, or institution rather than the participants' places of residence. Likewise, participant observations are made at specific times and during specific events. Similarly, the interviews focus on the identified topic and events (Morse & Field, 1995; Roper & Shapira, 2000). Morse and Richards (2002) noted that participant observation may be omitted in a focused ethnography; however, other researchers refuted this idea because they considered participant observation the hallmark of ethnographic research (Brink & Edgecombe, 2003; Roper & Shapira, 2000).

## Setting and Sample

I conducted this study at AKU over a period of four months—March to June 2006—and I used both purposive and theoretical sampling. According to Morse and Richards (2002), in purposeful sampling the participants are selected based on their required characteristics, whereas in theoretical sampling they are deliberately invited in accordance with the theoretical scheme or categories that have emerged from the data. I selected participants based on the phenomenon under investigation, their ability to articulate, their willingness to talk and reflect, and the time that they had available to participate in the study. Within the purposive sample, I followed the maximum variation sampling strategy (Polit et al., 2001). I selected key informants based on variations in their designation, work experience, and area of work.

As noted earlier, the aim of this study was to explore the competence of nurses who had graduated from the BScN program at AKU-SON and who were working at AKUH. Although various stakeholders such as nurse teachers, nursing director, patients, and other health care colleagues could have commented on the competence of BScN nurses, I felt that the graduates themselves and their immediate supervisors (head nurse or equivalent) would be in the best position to observe this phenomenon extensively and comprehensively because it is the head nurse of a unit who sets performance expectations for her staff and monitors their performance on a daily basis. Head nurses have the opportunity to observe as well as hear from others, including patients and health care colleagues, about the performance of their staff. Similarly, graduates can reflect on their experience and identify what is expected of them in the nursing workforce, whether they meet such expectations, and why they can or cannot do what is required of them.

In view of the above factors, initially, I considered two groups at AKU—BScN graduates and their supervisors (i.e., head nurses or their equivalent)—as potential participants for this study. However, while negotiating access to the study site, I extended the potential group of supervisors from head nurses/designees to nurse managers, as elaborated on in the following section. Likewise, after a few initial interviews, the data indicated that turnover of BScN graduates at AKUH was a significant issue that was affecting perceptions about BScN nurses. There was various speculation about this issue. However, to obtain first-hand information about the graduates who had left AKUH and were now working in other institutions in Pakistan, I recruited participants from that group of graduates by using a snowball sampling approach in which I asked members of the earlier sample to refer other potential participants who might contribute to the study (Polit et al., 2001; Morse & Richards, 2002).

### *Gaining Access to the Field Site*

In this study, entry to the field site and access to the potential participants were negotiated at different levels. Before presenting my study proposal to the Health Research Ethics Board at the U of A (HREB–U of A), I contacted the Dean of the School of Nursing at AKU and the Nursing Director of Aga Khan University Hospital (AKUH) and informed them of the intent and design of my study to seek their support with regard to viability of this study. Along with the study proposal, I submitted their letters of support to the HREB–U of A. After I received approval from the HREB–U of A, I sought approval from the Ethical Review Committee at AKU (see Appendixes A and B).

Upon approval from the ethics boards, I formally met with the Director of Nursing Services, AKUH. The purpose of this meeting was twofold: first, to give her an overview of my study, particularly the data collection strategies, and to seek her approval and facilitation in this process; and second, to discuss any rules or policies to which I must adhere while I was on the units for participant observation, such as the need to wear an identification card and comply with a reporting relationship. In this meeting, I requested permission from the Director of Nursing to present information about the proposed study at a meeting of the nursing management group in the hospital, which consists of nurse managers, shift supervisors, and clinical nurse teachers and which the Director of Nursing chairs. Likewise, I requested a list of all four-year BScN nurses who were working in the hospital. I was given a list of 95 graduates who had joined Nursing Services between 2001-2005 at the completion of their BScN program.

A week after my meeting with the Director of Nursing, I presented the proposed study to the nursing management group and gave them a handout of the presentation. Overall, it was a lively meeting. Members of the group asked questions, sought clarification about the scope and design of the study, and advised me to include nurse managers as potential participants from the supervisory group because a number of head nurses on the units were comparatively new in their position. Because nurse managers are responsible for a number of units, they are not involved in the direct supervision of staff nurses. However, because of their longevity in Nursing Services, the nursing management group thought that nurse managers would be better informed about the human-resources situation in their areas. I accepted this suggestion in consultation with my supervisors and with the approval of HREB–U of A and ERC-AKU.

Other than requests for clarification and suggestions, the members of the management group had no reservations about my request for participant observation, and they were comfortable with my proposed criteria for selecting units for my participant observation. I was permitted to choose any unit that I considered appropriate and then required to inform the nurse manager of the unit about my decision. In addition, the nurse manager of Nursing Education Services was assigned to work as a liaison person between the Director of Nursing and me. The assigned manager served as a facilitator in orienting me to Nursing Services. She guided me on a tour of the hospital and introduced me to the head nurses and clinical nurse instructors in the hospital. She also worked as a resource person whenever I needed information pertinent to the division of Nursing Services. Hence, she was one of the key facilitators in my study at AKUH.

As with the Director of Nursing Services, I also had a meeting with the Dean of AKU-SON. I presented her with a copy my study proposal and briefed her on my plans for the data collection. Upon my request, the Dean offered me a private room in the School of Nursing to be used as an office cum interview room for the duration of my data collection at AKU. I was also permitted to access all of the facilities, including help from the secretarial staff of AKU-SON. I used one of the secretaries to prepare and hand deliver the invitation letters to the potential participant.

### *Recruitment of Participants*

After obtaining the list of BScN graduates from the Director of Nursing Services' office, I enclosed copies of the invitation letter (Appendix C) in plain envelopes and requested a secretary at AKU-SON to label these envelopes with the graduates' name and units as indicated on the list. According to this list, the graduates were working in 21 areas of the hospital that included inpatient units, consultant clinics, and nursing education services. Out of 21 units, only 10 had three or more graduates; other areas had only 1 or 2 graduates. I also asked the secretary to prepare envelopes for the unit head nurses who had at least 3 or more graduates working with them, and she hand-delivered all the letters and a copy of the poster that contained information about the study (Appendix D) to the receptionist on each unit. The secretary then asked the unit receptionists to place the posters in a visible place, such as in the nursing lounge or medication room, and to give the letters to the concerned individuals; that is, the graduates and the head nurses/designates. Following this procedure for the delivery of the invitation letter, the secretary updated the list of graduates with the help of information from the unit receptionists. However, only 60 out of 95 graduates on the list were located; the rest had left the institution, but the records had then not been maintained accordingly.

A few days later I toured the hospital with the Manager of Nursing Education Services, and she introduced me to the head nurse on each unit. I briefly explained my study to them and asked whether they had received a letter of invitation to participate in it. I gave them an opportunity to ask questions if they had any concerns about the study or about their participation in interviews. Many of the head nurses indicated their interest in being interviewed and asked about the duration and location of the interviews, and other head nurses asked about the timelines and my availability to conduct the interviews. I explained that I would conduct interviews at any time during the next two to three months, depending on their availability. At this point I also gave them the option of being interviewed at home on a weekend if they preferred. Similarly, many graduates showed their interest to participate in the study when they saw me in the school, in a hall way on the campus, or in the units during participant observation. Reflecting on my experience with the head nurses, I realized that, although the head nurses wanted more information, they had not called to ask questions until I approached them personally. Apart from the reality that staff nurses work rotating shifts, I learned from ex-colleagues and friends that the hospital is short staffed and therefore many nurses are overworked. Hence, I made follow-up calls to some graduates who had shown some interest to participate in the interviews, but had not called back to make an appointment. When the potential informants confirmed their interest in my study or agreed to be interviewed, I gave them a detailed information letter about the interview (Appendix E).

### ***Sample Size***

The sample of this study may be described in terms of key informants and secondary informants. A total of 24 key informants and 30 secondary informants comprised this study. The key informants were those participants who met the specific selection criteria and contributed to this study through formal, extensive interviews. Secondary informants were those participants who did not meet any specific criteria, but contributed to this study via informal, accidental conversations during the course of my data collection at AKU, which enhanced my understanding of the phenomenon under consideration.

Of the 24 key informants, two thirds were graduates and one third were supervisors. The criteria for the graduate category included all four-year BScN graduates from AKU-SON who have some work experience in any constituency of AKU (the school or the hospital) after the completion of their program. The criteria for the supervisor category included all administrative personnel at AKU who have been supervising BScN graduates in a formal role such as head nurse, clinical nurse teacher, or nurse manager. The secondary informants consisted of a wide variety of people such as nursing students, faculty members (nursing and nonnursing), staff, and administrators. I would often meet these informants in a hallway on campus, in the faculty seminar room at AKU-SON, or during a refreshment break after professional gatherings; and after inquiring about my research topic in an informal conversation, they would share their perceptions of BScN graduates.

Unlike in quantitative research, the sampling principle in qualitative research focuses on the richness of the data instead of representativeness to accurately "portray the full context of the piece of reality through which the research focus is addressed" (Germain, 1986, p. 152). To ensure richness of my data, I followed the maximum variation sampling strategy by recruiting informants who had experience with the phenomenon at varying levels; hence, they helped me to view the phenomenon of interest from various perspectives. The participants from the graduate category varied in gender, year of graduation, designation, and area of work. Similarly, informants in the supervisory category varied in professional qualifications, years of experience, and level of supervision of the graduates. However, all informants in the supervisory category were female because in the entire division of Nursing Services at AKUH there was only one male nurse manager, but no male head nurse or clinical nurse teacher. Hence, the anonymity of that individual would have been difficult to ensure if I had included him in the sample. Because this study focused on an exploration of the competence of BScN nurses in general rather than the competence of the individuals, I did not recruit graduates and their supervisors in pairs. I also recruited supervisors and graduates from different units, except for one unit, but this was by chance. Similarly, I did not include more than two graduates from the same unit as I wanted to include nurses with varied work experience.

The adequacy and appropriateness of the sample are two important factors in evaluating the scope of the sample in qualitative research (Morse, 1991; Morse & Richards, 2002). *Adequacy* refers to the sufficiency and quality of the obtained data, and *appropriateness* refers to the methods used for sample selection (Morse, 1991; Polit et al., 2001). The sufficiency and quality of information that I obtained from the key informants and through my participant observations assured the adequacy of the sample size. I also capitalized on the information and the direction of the information that secondary informants offered, and I kept expanding and confirming the categories of information that emerged from my initial assessment of the data. As I explained earlier, I made an effort to select key informants who had knowledge and/or experience of the phenomenon from various perspectives. I continued my inquiry until I had sufficient data in each category and I was able to see clear patterns in my data. I stopped the inquiry when the data offered no new questions or directions, but became sensibly consistent and free of gaps. In other words, I had reached saturation, a point when "no new data add to the emergent patterns or themes and no new dimensions of insights are identified that can shed light on the research questions" (Germain, 1986, pp.152-153).

## Data-Collection Strategies and Procedures

Focused ethnography allows multiple data sources when the search is for themes, patterns, meanings, and understanding (Fetterman, 1989; Morse & Richards, 2002; Muecke, 1994; Roper & Shapira, 2000). However, it is important to clarify that the purpose of using various data-collection strategies is to view the phenomenon under investigation from different angles, but not necessarily to validate one piece of information against another. However, when information obtained from one source of data collection complements, corroborates, or explains information obtained from another source, it enhances the understanding of the phenomenon and hence increases confidence in the validity of what has been found. I used four data-collection strategies in this study: semistructured interviews, participant observation, a review of institutional documents pertinent to the phenomenon of study, and a field journal.

As a data-collection strategy, participant observation provides the researcher with an opportunity to observe what people say and do in actual, everyday situations. Thus, it enables the researcher to combine theoretical and practical truths to develop a holistic understanding of the topic under investigation (Fetterman, 1989; Spradley, 1979). On the other hand, inferring the existence of particular emotions, attitudes, values, or preferences from mere observation could be risky; therefore, self-reports via formal or informal interviews are necessary to enhance the credibility of observed data in the field (Stommel & Wills, 2004). In the current study, semistructured interviews were the key source of data collection, whereas participant observation and a review of the institutional documents helped me to explain, substantiate, and develop insights into the phenomenon of inquiry.

### *Semistructured Interviews*

Morse and Richards (2002) suggested that open-ended questions for semistructured interviews may be developed in advance when the researcher knows enough about the phenomenon but cannot anticipate the answers. Likewise, semistructured interviews allow enough information to be elicited and patterns to be identified in the investigated phenomenon because the same questions may be asked of all participants, but not necessarily in the same order. Basically I used two sets of guides for semistructured interviews to elicit data from BScN graduates and their supervisors (Appendix F). However, I modified the questions according to the role or background of the specific informants. For example, graduates who worked in the AKUH, AKU-SON, or outside the AKU got slightly different questions. I asked the questions with both planned probes such as "Why or why not?" and unplanned, unanticipated probes such as "Please elaborate on . . . "; "For instance . . . "; "Give me an example of that"; and "What makes you think that?" I pilot-tested the questions with a professional colleague who was a master's student at AKU-SON and made a few minor changes upon her advice.

The interview guides contained questions that elicited a description of competence, the expected performance of the graduate, the adequacy of the BScN program in preparing competent nurses, and the perceived level of competence of graduates in the nursing workforce. In addition, I also inquired about gaps or areas that needed improvement in the curriculum. Although the wording of my questions for the graduates and the supervisors varied to a certain extent, the questions sought information on the same phenomenon. For example, I asked the head nurses, "To what extent are BScN nurses prepared for what is expected of them in the nursing workforce?" Similarly, I asked the graduates, "To what extent has your professional education prepared you for your current work?" and "What are you able to apply that you have learned in your professional education?"

I conducted all of the interviews in my office at AKU-SON, except for one interview that I conducted in the head nurse's office because of the informant's preference. I interviewed most of the informants in the supervisor category during work hours and most of the informants in the graduate category before their shifts or, in a few cases, after their shifts. With some exceptions, most of the interviews lasted from 60 to

90 minutes. One interview lasted only for 25 minutes because the informant responded to each question in a manner that offered no opportunity for further probing. The amount of time depended largely on the amount of information the participant was willing to share as well as the need for probing and further information. All informants consented in writing to be interviewed (Appendix G). I recorded most of the interviews on a digital ICD recorder, but two informants preferred to respond partially in writing because they needed more time to reflect or they wanted to articulate their responses more succinctly in writing. Both of these interviews took more than two hours to complete.

In the first part of the interview I asked the interviewees whether they had any questions about the study or any concerns about the interview and then proceeded to solicit their consent to be interviewed. They signed the consent form in duplicate: one copy for my record and the other for their own records. I then obtained the biographical details of the informants, which consisted of age, gender, marital status, highest professional qualification, designation, years of experience in nursing, area of work, and length of stay in that area. In this part of the interview I also gave the interviewees a copy of my questions (without probes) to give them an idea of the nature of the questions as a result of feedback from the first interviewee, who commented that "I was a bit anxious as what is going to be the next questions. It would have been better if I knew the questions beforehand." Successive interviewees who had a chance to read the questions reported that it helped them to understand the questions better and to overcome their anxiety about the unknown. In addition to the above, I advised the interviewees to avoid introducing themselves by name at the beginning of the recording and mentioning the names of people during their conversation if possible. Concomitant with the purpose of this study, I asked the informants from the supervisor category to reflect on their experiences with different graduates to illicit a general perception of the competence of graduates rather than a perception of the competence of individual nurses who worked under their supervision.

At the beginning of the interview each participant introduced him- or herself as ABC or XYZ, gave the date, and reported whether it was their first or a follow-up interview. Most of the interviews were conducted in English. In some cases the informants used words or phrases from Urdu while they conversed in English, and one interview was almost entirely conducted in Urdu. In that case, to ensure the interviewee's comfort, I also spoke in Urdu after my initial questioning and probing in English. Because I have a good grasp of both languages, Urdu and English, I was able to adapt to the situation easily. I used a separate copy of the interview guide for each informant and wrote key words, phrases, or any significant nonverbal behaviours that I observed in the interview on that sheet to enhance my interpretation. Such notes served to prompt my memory while I listened to the recording or read the transcripts and therefore enabled me to see beyond the words that appear in the text.

As mentioned earlier, I recorded the interviews on an ICD recorder. After completing each interview, I transferred the data from recorder to my computer and saved the interview as a voice file with a pseudonym. I used the same pseudonyms for my key informants in the analysis and discussion of the research information. I then deleted the recording from the recorder and copied the voice file onto a CD for the transcriptionist and onto a flash drive as a backup for my computer file. I noted the identification number of the interview on the top right-hand coroner of the consent form and filed it in a ring binder that I always kept in a locked filing cabinet. After ensuring the security of the interview data, I reflected on the content and process of the interview and noted it in my field journal. I reflected on how the recent interview was different from the others, what I learned that was new, what I needed to explore more or confirm with others, and what I liked or did not like about the interview.

To protect the informants' identities as well as to avoid any misidentification, I chose pseudonyms that were different from any of the 132 graduates' (2001 to 2005) real names. I used a similar process for the nursing supervisors who were employed at AKUH in 2006. To make it easy to distinguish the informants in each category, I assigned the graduates pseudonyms that start with the letters A through K and the supervisors, pseudonyms that start with the letters M through S, as shown in Table 2.

A competent professional with a good command of English and Urdu transcribed most of the interviews verbatim. This person was not an employee of AKU and consented to follow the measures to maintain confidentially in handling the raw data. I transcribed three interviews myself: one that was conducted completely in Urdu and two that were partially handwritten and partially recorded. I then sent each transcribed file to the respective informant for a review for accuracy before our face-to-face follow-up meeting.

Table 2

*Pseudonyms of the Key Informants*

| | Graduate category | Supervisor category |
|---|---|---|
| Female | Aamna, Aisha, Anum, Atya, Bahaar, Deeba, Diya, Hirah, Huma, Kanwal, Kiren, Komal | Madiha, Mashal, Meher, Moona, Nidah, Saher, Sairah, Sana |
| *Male* | Adil, Bilal, Daud, Hamid | |

For the interviews that contained some Urdu words and phrases, I instructed the transcriptionist to transliterate the Urdu words and highlight them, in addition to translating them into English. I read each transcript, and, using the voice file, I compared it with the informant's interview for accuracy. I made some changes in the translation of Urdu into English if necessary, but I retained the roman type (transliteration) in the transcript until each informant verified it. In one case I asked an informant to help me to transcribe the interview because of my difficulty in understanding that informant's accent in the recorded conversation.

With regard to the English translations, some words in Urdu do not have an equivalent in English. For example, *Baichari* in English might be "poor girl"; however, *poor* translated into Urdu is *Gareeb*, which refers to poor in the economic sense. *Baichari* is not used in the economic sense, but rather refers to someone's helplessness. Therefore, in such cases I used an English word that captured the intent of the word or phrase in the given context. I marked these words or phrases and brought them to the attention of the concerned informants during a follow-up session.

I scheduled a follow-up, face-to-face interview or conversation with 18 of the 24 participants for the purpose of clarification and/or elaboration of their transcripts. These sessions lasted for 15-30 minutes. One participant also asked me to delete some information from her transcript. After having made these changes on the hard copy of the transcript, I made the amendments in my computer file by electronically tracking the changes. I then copied all of the amended files into a separate folder that I named *Confirmed Transcripts* and later used them for my content analysis. The technique of concurrently gathering the data and conducting the analysis gave me the opportunity to validate the data that I had gathered from previous interviews to fill in the gaps or double-check the information with the concerned participant or crosscheck it with other participants. I emailed the transcripts of my initial two interviews to my supervisors in Canada to seek feedback on my ability of conducting the interviews.

### *Participant Observation*

As noted earlier, I used participant observation to substantiate the information that I gathered from the interviews. The competence of nurses is greatly affected by factors in their work environments, including staffing patterns, praise and recognition, conflicts and cooperation, and control and responsibility (Aiken et al., 2002; Roberts, Jones, & Lynn, 2004; Sasichay-Akkadechanunt, Scalzi, & Jawad, 2003). Because the institutional context and interpersonal dynamics among staff are known to influence the ability of a graduate nurse to perform in the nursing workforce (Casey et al., 2004; Godinez et al., 1999), some participant observation was necessary for me to gain a holistic understanding of the phenomenon; that is, graduates' competence. For example, in their interviews many participants referred to contextual issues in relation to graduates' performance, such as workload, staffing level, and high accountability and stress; and participant observation helped me to make sense of their experiences and perceptions.

I was a participant observer on two units that I chose based on the following criteria: (a) They had a higher proportion of BScN nurses on the unit; (b) the context varied, such as a critical care versus a non–critical care unit; and (c) the structure of the unit was physically conducive to observing staff interactions without interfering in direct patient care. Therefore, I did not consider operating theatres, outpatient areas, and emergency rooms in this selection. Once I had identified the units for observation, I informed the nurse manager of each unit, which I followed up with a meeting with the unit's head nurse. With the permission of the head nurse, during the shifts overlap in the afternoon, I made a short presentation to the unit staff on my study, including my plan for participant observation and its possible impact on them (Appendix E). To reach the maximum number of staff in the chosen units, I repeated my talk several times. After each presentation, I distributed the consent form (Appendix G) to the staff in attendance and requested that they complete the form without consulting any another individual and put it in the identified cardboard box. Later, I collected the forms and made a list of those who had consented to participate. Each month during my data collection, I asked the head nurses for a duty roster, which enabled me to see which of the staff members who had consented to participate, were on duty on a particular shift.

In total, I spent 43 hours on participant observation, 22 hours in the North unit and 21 hours in the South unit. These units are further described in the next chapter. I conducted the observations intermittently with the interviews from April to July 2006. The length of my observations ranged from 2 to 6 hours. I began the observations on weekdays during the morning shifts and, later, observed during evening and night hours, including weekends. It was necessary that I obtain a sampling of observations on all shifts because the roles of the staff and the nature of the events vary from evening and night shifts to morning shifts. As noted above, the purpose of my observation was to understand the context of nurses' work, not to view the interactions between nurses and patients.

During the observation I assumed the roles of participant-as-observer and observer-as-participant. Following Burgess's and Byerly's work, Roper and Shapira (2000, p. 17) noted four levels of participant observation based on the investigator's involvement in the setting: (a) the complete participant, (b) the participant-as-observer, (c) the observer-as-participant, and (d) the complete observer. The complete participant immerses him-/herself in the field without self-identifying as a researcher, which has ethical implications (Fetterman, 1989). In contrast, the complete observer is completely withdrawn from any social interaction in the field; hence both of these might equate with covert research, which is ethically unacceptable (Hammersley & Atkinson, 1995; Moore & Savage, 2002). However, in the participant-as-observer or observer-as-participant role, the researcher is known to the participants in the setting and gathers data through formal and informal interactions. The difference between these two roles is the extent of the researcher's participation and his/her degree of formality. In the observer-as-participant role, the nature of the contact is brief, more formal, and intermittent along with interviews. In the participant-as-observer role, usually the investigator undertakes prolonged observation in the field to fulfill this role, unless he/she is already an insider. Nevertheless, it is more appropriate to view different roles within participant observation on a continuum rather than in rigid categories, because in reality, depending on the circumstances in the field, one may have to switch back and forth between these roles (Roper & Shapira, 2000).

As noted earlier, although I was not a complete insider at AKUH, I was also not a complete stranger at the field of this study. Therefore, my role varied between observer-as-participant and participant-as-observer as the situation warranted. For instance, in watching the interactions among nurses in a shift report or in an inservice session, I assumed the former role; whereas in interacting with the head nurse or clinical nurse teachers to obtain information, I assumed the latter role. On many occasions I observed the activity on the unit, which required more information to understand it from the staff perspective. For example, in one interaction between the head nurse of the unit and a medical doctor, the doctor was apparently angry and almost shouting at the head nurse because someone had removed the overhead projector from the seminar room on the unit. The head nurse appeared calm and replied that no one had borrowed the projector from her. Later, I asked the head nurse for more information to understand the basis of this interaction, particularly the reason why the doctor held her accountable for a piece of equipment that was not kept in a locked room on the unit. The head nurse responded, "We are told that the role of the head nurse is like the mother of the unit, so we are supposed to be accountable for everything that happens on the unit."

I made both descriptive and focused observations (Spradley, 1980; Streubert-Speziale & Carpenter, 2003) related to the nurses' work environment. Streubert-Speziale and Carpenter explained that observation does not mean merely looking at something, but that the researcher must "look, listen, and ask questions" (p. 166). In my first week on the unit, I began with general, descriptive observations and made an effort to socialize with the staff to establish rapport with them. The purpose of my general observation was to determine what was occurring on this unit. For instance, during the descriptive observation I examined the physical setup of the unit and collected data to answer the following questions: "Who works on this unit? What is the nature of their work? What roles do they perform? Who are the decision makers and who are the followers? What factors in the work environment facilitate or impede nurses' performance? In terms of focused observations, I attended specific events such as the shift report, unit rounds, and inservice sessions. For selective focused observations, I followed Agar's (1980) notion of the five Ws and an H: "who, what, when, where, why, and how?" (p. 92).

During my observations on the unit I carried a small notepad in my pocket, and as the situation warranted, I jotted down field notes in the form of key points with the dates and times. Then usually within 3 to 9 hours, I elaborated on these handwritten key points or cues in a Word document on my computer. In other words, these notes took the form of a reconstruction of my observations and of conversations on the units, and were used to supplement the interview data. For ease of access and retrieval, I recorded the field notes in chronological order for each unit separately. I used three columns, one for the date and time, the second for my observations or descriptive notes, and the third for my interpretation of these descriptive notes, including my hunches, surprises, queries, and need for further exploration or follow-up. In this column I also commented on the connections between the themes that emerged from the interview data and my observations the in the work environment.

According to Agar (1980), the term *participant observation* suggests direct involvement of the researcher in the community life of the people being studied. This concept is more relevant to traditional ethnography, but it is also applicable to focused ethnographies in a modified form. I participated in various activities with the staff other than patient-care delivery; for example, I observed staff interaction at a nursing station and during shift report, attended their inservice sessions, and joined them over the tea and meal breaks. In addition to these activities on the two units at AKUH, I attended other events on campus that were relevant to the context of this study, such as the celebration of Nurses' Day, a presentation of the Joint Commission of International Accreditation's survey, and presentations by final-year BScNs students after their final practicum at AKUH.

### *Review of Documents*

Like participant observation, a review of relevant documentation on the phenomenon under study supplemented the data from the interviews. During the interviews with the key informants or informal conversations with secondary informants and in the preliminary analysis of the interviews, I often realized the need to review a particular document. For example, one informant in the graduate category reported that, on joining AKUH, he had felt "very annoyed" when he learned that there was no difference in the employment grade and job description for BScNs and diploma-prepared nurses other than a small increase (6%-7%) in their salaries. However, in his view, there were substantial differences in their admission criteria, the educational fees, and the length and quality of their professional preparation. Similarly, both graduates and supervisors had different perceptions of the orientation programs for nurses at AKUH. In view of these discrepancies, I reviewed the relevant documents, including job descriptions, the career ladder, and orientation programs for nurses at AKUH, to expand my understanding of the participants' perspectives (see Appendix H).

### *Field Journal, Memos, and Personal Diary*

In addition to the field notes that I took during my participant observation, as I explained [illegible], I maintained a field journal, which was a kind of personal diary to record what was happening every day during the period of my data collection. This included my thoughts; hunches; reflections; personal feelings such as anxiety, comfort, disappointment, or surprise; and the reactions of others towards me. I also recorded all of my informal conversations with secondary informants in this field journal. Likewise, I noted my impression of each interview. During the formal analysis of the data, I kept track of my thoughts on the analytical schemes, including difficulties and insights, in form of memos (Morse & Richards, 2002; Streubert-Speziale & Carpenter, 2003). I wrote these memos in a Word document with the date and identification number and a brief description pertinent to the analysis in general or to a specific question as required.

I wrote the field journal as a Word document that consisted of four columns: the first for the date and time when I wrote the journal; the second for the type of notes in the journal—whether personal, methodological, or theoretical (Germain, 1986; Hammersley & Atkinson, 1995; Mayan, 2001); the third for actual notes; and the fourth for my thoughts and reflections. To access the pertinent record with ease, I highlighted the content in my field journal with different colors, such as yellow for hunches, hypotheses, and follow-up; purple for content that needed attention during the analysis and discussion; and green for recommendations. To share my progress and the constraints of the fieldwork, as well as my thoughts and reflections on the data, I sent my journal to my supervisors via e-mail on an ongoing basis and benefited from their guidance and encouragement on the fieldwork.

## Data Analysis

In accordance with the traditions of qualitative research, I collected and analyzed the data concurrently rather than separating the phases of data collection and analysis (Agar, 1980; Creswell, 1994; 1998; Hammersley & Atkinson, 1995; LeCompte & Preissle, 1993; Roper & Shapira, 2000; Spradley, 1980; Streubert-Speziale & Carpenter, 2003). Morse and Richards (2002) referred to this process as "data making" (p. 30). Boyle (1994) asserted that the researcher "does hold preexisting theoretical interest and these interests guide the questions and observations. Answers to the questions and observational data are used to develop more inquiries and hunches" (p. 181). Therefore, the process of data collection and analysis may be viewed as a constant validity check (Bernard, 1988; Boyle, 1994; Field, 1983). It requires switching back and forth between the etic perspective (the researcher's assumptions, ideas, questions, and explanations) and the emic viewpoint (the researcher's observations, informant reports, and interviews) and testing the first against the second to identify explicit and implicit patterns. As noted in the previous sections of this chapter, I followed this approach during my fieldwork at AKU. The phase of my preliminary data analysis and collection, or data making, continued until I gained as broad a picture of the topic as I could possibly have.

### *Organization of Data for Content Analysis*

After my four month of fieldwork in Pakistan, I returned to Canada and began to refine and expand the preliminary analysis that began during the data-making process. I reviewed each set of data—that is, the transcripts of the semistructured interviews, my field notes, and my field journal—and organized it for content analysis. Although I stored and organized all of the data in Microsoft Word files, I sorted the data manually for themes and categories (Morse & Field, 1995).

First, I numbered the lines of the text of the interviews. Then I read the transcripts and collated the informants' responses to each question in a separate file and saved it according to the question number and its brief description. Collating the responses according to the questions is a pertinent procedure for semistructured interviews (Morse & Field, 1995). It is important to mention that the collation was a two-step process: (a) I copied the informants' responses to each question as they occurred in the transcripts, and (b) after reviewing the complete text, I cut and pasted the narratives that appeared to be relevant to other questions and cross-referenced them in both files. For example, many informants underscored curriculum gaps and offered suggestions for improvement while they were reflecting on their experience and responding to the question on how well BScN graduates are prepared for what is expected of them.

I organized the document that contained the collated responses to each question into three columns. The center column contained the text (the informants' verbatim responses) that I copied from the individual transcripts, the left column showed the coding, and the right column included my thoughts and comments on the text. I identified the text according to the informants' pseudonyms and the line numbers from the transcripts. In addition, I assigned an identification number (1, 2, 3, etc.) to each individual's text. Identifying the text with the informant's pseudonym helped me to visualize the informant while I read his/her response and to make sense of it, whereas numbering the text made it convenient to identify patterns during the coding and categorizing exercise. To identify patterns in the informants' views on a specific question, I collated the responses in a certain order. First, I copied the responses from all of the informants in the supervisor category and arranged them according to their designation of head nurse, clinical nurse teacher, or manager. If I had asked the informants in the graduate category the same question, I then copied their responses and arranged them according to the year of graduation and their gender. After this collation and organization, I read the text under each question and removed affirmation or acknowledgment words such as "Mm-hmm" or "Okay" for better flow of the text, but I left stuttering sounds such as "Um" or "Uh" to determine the fluency of the informants' thoughts in the context.

### *Content Analysis*

Once I had completed the above organization, I proceeded with the content analysis. The literature has identified several forms of qualitative content analysis that range from impressionist, intuitive, interactive, and interpretative to systematic, strict, textual analysis (Hsieh & Shannon, 2005; Miles & Huberman, 1994; Polit & Beck, 2004). Morse and Field (1995, p. 136) referred to this continuum of analysis as *latent* and *manifest* content analysis. In latent content analysis, the researcher focuses on the meaning and underlying intents of the messages displayed in text; in manifest content analysis, the researcher looks for words, ideas, or phrases in the text that are central to the research and use them for descriptive statistics. In Morse and Field's view, although numeric objectivity increases the reliability of the process, its validity is low because the richness of the context is lost. Accordingly, I used a mix of latent and manifest analysis. I determined how many participants referred to a specific characteristic or behavior of the graduates and its underlying meaning or intent. For example, many informants in this study talked about graduates' assertiveness; however, sometimes they perceived this ability as a strength, whereas at other times they considered it a weakness, depending on whether the graduates were communicating with physicians, nursing colleagues, or members of the nursing management.

I read through the entire text for each question; highlighted words, phrases, or paragraphs pertinent to the question; and noted possible categories. After having this rough scheme of categories in mind, I reread the text and coded the recurrent words and phrases. I underlined these words and phrases in the text and then copied them to the left-hand column. In other words, I used *In Vivo* coding (Miles & Huberman, 1994). At this point I used as many codes as possible to ensure a thorough coverage of the informants' accounts (Morse & Field, 1995; Morse & Richards, 2002). Concurrent with the coding exercise, I opened a new document to aggregate the codes or clippings in relevant categories. As I copied a code (words or phrase) into the categorization document, I identified it with its origin via the informant's identification number. Similarly, in the coding document I noted the short form of a category where I had copied the code. For repetition of a code, I kept adding the number of each informant. Once I had aggregated all of the codes or clippings, I reexamined the categories to determine whether all of the clippings were consistent in meaning or whether subcategories were emerging and reflected on whether the label of a category best represented all of the codes.

I compared and contrasted the data as I compiled more information within each category; as a result, some categories or subcategories emerged, while others were merged. When, I sorted the major categories into smaller ones, I looked for atypical cases and representative cases. Atypical cases consist of anecdotal and negative cases (Denzin, 1978; Morse & Field, 1995). Morse and Field explained that "representative cases appear with regularity and encompasses the range of behaviors described within a category. The anecdotal case appears infrequently and depicts a small range of events that are atypical of the larger group" (p. 139), whereas negative cases present views that are opposite to the emergent theme or proposition. Both anecdotal and negative cases help to verify the significant behavior or characteristic found in the research.

I also reflected on categories to identify themes that connected them; in other words, I searched for patterns in the big picture of my inquiry. I wrote a summary for each question that consisted of themes and categories and accounted for all of the ideas in that category (Mayan, 2001). I then selected some exemplars from the informants' narratives to support my analysis and interpretations of their views. As noted earlier, interviews were the main source of my data collection, and the data from my field notes and field journal helped to supplement the data from the interviews. Hence, during the content analysis exercise I kept referring back and forth to my field notes and field journal. Likewise, I compared the findings from previous studies with the data that I had collected from the participants to verify and extend the analysis. Morse and Richards (2002) referred to this as "shadow comparison" (p. 151).

I wrote memos to keep track of my thoughts and key decisions during analysis. Although I was the sole data collector, throughout the study I worked in consultation with my supervisors. I held meetings with them at various stages of the analysis, as described above, and through consultations and discussions they helped me to broaden my thinking and enhanced my analytical ability by offering their expert advice and fresh perspectives. In addition to my supervisors, I shared my interpreted data with professional colleagues and peers as a way of enhancing the validity and reliability of the findings.

### *Rigor of the Study*

Whether researchers use a qualitative or a quantitative paradigm, they must explain or demonstrate that their research is credible and not merely fiction. Although validity and reliability are the best known concepts in scientific research to explain rigor (Morse, Barrett, Mayan, Olson, & Spiers, 2002), many qualitative researchers prefer to use alternative concepts such as trustworthiness of data. Initially, Guba and Lincoln (1981) proposed three criteria to achieve trustworthiness: credibility, fittingness, and auditability. Later, they amended the criteria for trustworthiness to include credibility, transferability, dependability, and confirmability. Other researchers such as (Leininger, 1994; Meleis, 1996) suggested other criteria to evaluate the rigor of qualitative research. Morse et al. (2002) argued that most of the aforementioned criteria for rigor in qualitative research is grounded in the post hoc assessment and is greatly determined by external reviewers. Hence, they proposed shifting the onus for incorporating and maintaining rigor to investigators rather than to external evaluators. I adapted their recommended verification strategies to achieve rigor in this study.

Mayan (2001) described using verification strategies as "the process of checking, confirming, making sure, [and] being certain" (p. 26) that all of the identified threats to the data validity and reliability have been corrected in the process of conducting research. Verification involves strategies to check for investigator responsiveness, methodological coherence, sampling, data analysis, and theoretical thinking.

The investigator's responsiveness demands sensitivity, creativity, flexibility, and skill in the data-making process (Morse & Richards, 2002). Various steps discussed earlier in this chapter are reflective of the investigator responsiveness in this study. For example, I made changes in my sample plan after I entered the field site. Sensitivity towards gatekeepers—those who control access to the field—is highly emphasised in ethnography (Creswell, 1998; Roper & Shapira, 2000; Spradley, 1980), and therefore I made an effort to demonstrate respect towards the gatekeepers of my field site and shared my detailed plans of my data collection. I sought feedback from my participants on the interview process and benefited from that. Similarly, I was able to work around the limitation of language and related transcription challenges, as noted above in the section on semistructured interviews. I used inductive methods of investigation through a combination of data-collection strategies, collecting and analyzing data simultaneously, and maintaining field notes and a journal. Careful reflection on the data and constant self-questioning about why I was doing what I was doing helped me to sustain the required sensitivity and flexibility.

Methodological coherence is an important factor in verification for rigor that requires congruence or compatibility of the research method with the intended inquiry or research question (Morse & Richards, 2002). I have considered this factor in the design and methodology of this study in consultation with experts in qualitative research. Hence it is up to the discretion of the reader to evaluate this study for methodological coherence. Four data-collection strategies (semistructured interviews, participant observation, document review, and a field journal) helped me to obtain a range and depth of information. The use of divergent and complementary strategies to examine the research questions ensured the credibility of the findings.

In regard to verification of the participants' views, to a certain extent I began the process during the interviews. I shared my interpretation of a situation with them as appropriate and sought their clarification. I also verified the interview data with the participants by giving them a copy of their transcript, followed by a face-to-face meeting for discussion and clarification.

Issues of validity are of greatest concern in fieldwork because of the researcher's subjectivity, the participants' reactivity, and the impact of reciprocity between the researcher and those being researched (Brink & Wood, 2001; Morse & Field, 1995). In qualitative research the researcher functions as a research instrument. Hence, the quality of the data is subjectively influenced by the ability of the researcher to establish rapport and trust with the research participants (Morse & Field, 1995). As described in the Overview of the method section of this chapter, my status in the field was somewhat of an insider. Having been aware of the implications of being an insider (Agar, 1980; Creswell, 1998; Fetterman, 1989), I was cautious in my relationships with the participants. Although I followed the cultural norms and gestures to maintain rapport and trust with my research participants, I also made a conscious effort to estrange myself when the situation warranted to minimize the risk of overidentification and assumptions about knowledge. Lipson (a dialogue in Morse, 1994a) explained that "you can be a stranger without being a stranger—by shifting your consciousness to a different place" (p. 317).

Apart from the field notes, I wrote a field journal and notes to record the research context, the process of inductive inquiry, methodological decisions, the analysis process, and my personal responses to the study. Through constant reflection and introspection, I tried to make myself aware of biases, impressions, speculations, hunches, and insights that might bias or influence the findings (Agar, 1980; Burns & Grove, 1997; Piantanida & Garman, 1999). To Sandelowski (1986), these are measures of assurance of the reliability and validity of the findings.

Adequacy and appropriateness of the sample are important in verifying for rigor (Morse, 1991; Morse et al., 2002). To ensure sample appropriateness, I used purposive, theoretical, and snowball sampling in this study, as outlined in the Setting and Sampling section of this chapter. Similarly, adopting concurrent methods of data collection and analysis helped me to ensure efficient and effective saturation of the data. Saturation is achieved when specific themes or behaviours are noted repeatedly or the general picture reaffirms itself over and over again. Saturation of data or replication of information in each category ensures validity because it accounts for alternative ways of explaining the phenomenon. To enhance validity, I also sought negative and discrepant/anecdotal cases, which helped to build information to reveal contrary and less obvious patterns (Morse & Richards, 2002). According to LeCompte and Preissle (1993), a negative case refutes or disconfirms the emergent rule or obvious pattern, whereas a discrepant case is a variant of the emerging rule or obvious pattern. Searching for negative cases "makes the researcher conscious of pattern limitations" (p. 251), which is important in explaining and interpreting a construct.

As noted earlier, I used a concurrent data-collection and analysis process in this study, which is considered crucial to the rigor of qualitative research. It helped to avoid overaccumulation of data because I was able to set the direction for what was to be known on the basis of what was known. Mayan (2001) contended that "this moving back and forth in the process" (p. 27) not only helps the researcher to maintain focus on the study, but also offers a systematic way to check, monitor, and confirm data, Finally, adhering to the demand for theoretical thinking in the qualitative approach, I went through different steps of content analysis, as described in the Analysis section. I compared and contrasted the emergent patterns in this study with the existing literature on the phenomenon under study. Discussions with my supervisor, professional colleagues, and peers also helped also to validate my findings.

## Ethical Issues

Respect for individual autonomy, privacy, and confidentiality of information are the core issues in ethnographic research (Creswell, 1998; Hammersley & Atkinson, 1995; Lipson, 1994). The position of researcher-as-instrument, or subjectivity, is another concern (Morse & Field, 1995) because the relationships of the researcher and those being researched may affect the quality of the data. The dynamics of these relationships require special consideration if the researcher, like myself, is an insider rather than an outsider or stranger, because conducting research in one's own culture may "cause tension between strangeness and over identification" (Pellatt, 2003, p. 30). In the following section I will identify how I addressed these issues in the current study.

The procedure for obtaining consents has been detailed in the Data Collection section of this chapter. I obtained ethical clearance for this research from HREB–U of A and ERC-AKU and took specific steps to ensure the participants' right to autonomy and protect the confidentiality of the data as much as possible (see Appendixes E and G). I did not ask anyone to participate in this study unless he/she had given fully informed consent. The research participants were free to discontinue their involvement in the study or refuse to answer questions at any time without penalty or intimidation. Their participation in the study was voluntary. Sometimes during the interviews the participants asked me to stop recording our conversation. At other times, although they stated "This is confidential," they continued the conversation without asking me to stop the recording. In the latter cases I asked the participants whether I should stop the recording or remove that information from the transcript, and only one asked me to do so. I ensured that I respected the participants' wishes at all times.

For the purpose of maintaining the participants' anonymity and the confidentiality of their information, I advised them not to introduce themselves in the interviews with their real name, but rather to use ABC or XYZ. I assigned pseudonyms when I saved the voice files and used them in the analysis and presentation of the results. I noted the biographic information of the participants separately with an identification number in the order in which they appeared for their first interview and coded the consent forms accordingly. Later, I kept the biographical details and the consent forms in a locked cabinet in my office at AKU and a copy of the biographical detail in my personal computer for the purpose of analysis; I protected this file with a password. Similarly, I saved the voice files from the interviews on my personal computer I backed up before coming to Canada. I deleted all the data which were on my desktop before leaving AKU-SON. Like the interviews, I coded all of the information from my field notes to protect the participants' anonymity. A professional transcriptionist who adhered to the principles of confidentiality transcribed the interviews.

I have taken all precautions not to reveal the participants' identity. The analyzed data are presented in aggregate form instead of according to individual participants. Narrative excerpts from the interviews or field notes in my thesis, subsequent reports, presentations, or other publications will not include any data that could possibly identify the participants. I will keep the data from this study for at least five years. It is possible that the data from this study will be useful for future studies. However, a secondary analysis of the data requires approval from ERC-AKU. A copy of the transcripts has been stored with my co-supervisors at the University of Alberta and it will be discarded after five years.

As noted elsewhere, I conducted the formal interviews in this study during the participants' personal time before they began work or when they stayed after work. They were required to use public transport rather than their regular corporate transport for the interviews, and they were offered a nominal sum of money to compensate for their transportation costs. However, most participants were too embarrassed to accept money from a researcher whom they had known in some capacity in the past as a teacher, a manager, or a colleague. I know the norm of reciprocity in Pakistani culture, and I therefore used that money to buy them a gift and a thank you card, which I gave them at the conclusion of my fieldwork in Pakistan. Likewise, I gave the staff on the unit where I conducted my observations a box of chocolates with a thank you card.

Working in one's native country and a known environment has advantages and disadvantages. On one hand, the researcher does not have to worry about language barriers and the physical orientation of the place; on the other hand, it may lead to the researcher's making assumptions about knowledge (Agar, 1980; Fetterman, 1989). As mentioned earlier in the Rigor section of this chapter, at times I had to make a conscious effort to estrange myself from the setting and to be aware of my role and responsibilities as a researcher. In addition, I recorded my personal reflections in my field journal on a regular basis to identify my biases to overcome the risk of "going native" (Agar, 1980).

Being an insider, I was aware that I might have less accessibility to some of the participants if they still identified me with my previous administrative role in the hospital or my faculty role at the school and that they might fear that I would disclose their information to other faculty at AKU-SON. To minimize this issue, it was necessary for me to explain to the potential participants the intention of my study and the strategies of data handling in regard to confidentiality.

After being on the study site, I was struck by other realities of fieldwork. There was a considerable shortage of nurses in the AKUH. In addition, the hospital was preparing for an international audit (JCIA), and because of this, nurses at all levels were required to devote extra time to their jobs besides their usual responsibilities of patient care services; this included conducting or attending educational activities and performing internal audits. As a result, many nurses in the hospital were required to work overtime or double shifts. Because of these demands, it is not difficult to imagine that participation in research might have been their lowest priority.

Upon receiving their invitation letter, many of the potential participants voiced their interest to participate in the study. However, a follow up call was necessary required before the interview took place, which I found somewhat challenging. On one hand, I was cognizant that, because I am an insider to AKU, people might feel obliged to participate if I called them. On the other hand, I knew that most of the time the nurses at AKUH worked in challenging circumstances because of understaffing and their heavy workload. Hence, it might not have been convenient for them to call me for more information on the interviews and setup a convenient time for the interview. To overcome this situation, I was very careful in my approach to them as well as conscious of their response to my call. For example, after my greeting and introduction, I would always gauge if they were still interested to participate in the study. Following their confirmation, I asked whether they would be interested in receiving more information about the study. If the response was "No," it was a clear indication that they were not interested. However, I interpreted requests for more information or specific questions about the duration of the interviews or when they might be interviewed as signs of their interest. After giving them the required information, I always made sure to tell them that they were not obliged to participate, but could do so if they wished. I explained that the purpose of my follow-up call was to give them an opportunity to ask questions that they might not have had a chance to ask because of other priorities.

In general, being an insider made it easier for me to record the interviews and access most of the information that I needed. Yet I was always required to maintain vigilance to avoid intruding on the privacy of others unnecessarily. For instance, during the participant observation when I was having a conversation with a head nurse, a staff member wanted to consult her, and I volunteered to leave the office because I felt that patient care matters take priority. In another situation, when the nurse manager greeted us, I noted a nonverbal cue that she wanted to discuss something confidential with the head nurse, and I asked, "Would you like me to leave?" She responded with a smile to confirm my assumption. It is important to mention that in Pakistani culture candidness is not usually appreciated, particularly in dealing with someone who is respected. As result of this cultural nuance in interpersonal relationships, I had to behave cautiously to strike balance between my roles of inside observer and researcher.

## Summary

In this chapter I have identified the method and rationale for the current study based on the nature of the inquiry. Likewise, I have discussed the detailed plans and processes that I used in conducting study, which include the study site, the population, the sample and sampling, methods or strategies for data collection, the analysis, and rigor as well as the ethical considerations.

# CHAPTER FOUR:
# POPULATION AND SAMPLE

This chapter presents the demographics of all BScN nurses who graduated from AKU-SON between 2001 and 2005. To collect this data, initially, I obtained the demographic information of all graduates from the Student Affairs office at AKU, including gender, city of origin, and schooling background. Later, I acquired information on the current whereabouts of the graduates from their class fellows who participated in this study as either key or secondary informants. I also present the characteristics of the sample of this study as well as a brief description of the units at AKUH where I conducted my participant observation. Accordingly, this chapter has three sections: the characteristics of BScN graduates, sample demographics, and a description of the units.

## Characteristics of BScN Graduates

With the beginning of the BScN program at AKU-SON in 1997, the first cohort of students graduated in 2001, and a total of 132 students have graduated over the last five years. Of those 132, 100 (76%) students were female and 32 (24%) were male. Table 1 in Appendix I provides detail information about the provinces of these graduates. In terms of the graduates' schooling background upon enrolment in the BScN program, all except four—three females and one male—had an undergraduate degree; the rest were prepared at the intermediate (Grade 12) level. The majority (93%) came from colleges where the medium of instruction was English. Likewise, with some exceptions, the majority majored in science in high school.

Because of the AKU policy that requires that nursing students serve the institution for at least one year after their graduation, the majority of the graduates (92%) joined AKUH for their initial work experience in nursing. However, 25% resigned within one year, and about 20% left within the next one and a half years. In June 2006, 61 (46%) graduates were working at AKUH, which constituted about 10% of the nurses in the hospital. Table 2 in Appendix I shows that of the 61 graduates who were working at AKUH at the time of this study, the majority, 28 (46%) were from the class of 2005 and hence had had less than one year of experience, 12 (20% had more than one year of experience, and the remaining 21 (34%), from the classes of 2001 to 2003, had more than two years of experience. Likewise, out of 61, 53 (87%) were female and 8 (13%) were male; 32 (52%) were working in critical care area, such as intensive care units, recovery room, or emergency room, and the rest of them were working on general units.

Table 3, 4, and 5 presented in Appendix I provide detail about the work history of these graduates. Of the note, the turnover of graduates at AKUH has been higher for male than for female. Of the total graduates (n=132), approximately a quarter (24%) of them have left the country, 60% are working in Pakistan, and 9% are not working. Of those graduates who were working in Pakistan, five from the initial cohorts (2001 and 2002) have obtained a master's degree in epidemiology or business administration (MBA), whereas eight graduates from the classes of 2001 to 2004 were pursuing a master's degree in various programs, including epidemiology, health policy and management (HPM), nursing (MScN), and public health. Two who have completed a master's degree have left the nursing profession.

In summary, 132 nurses graduated from the BScN program at AKU-SON since its inception in 1997. Gradually, the number of graduates has increased with each cohort. The majority of the students in the program were local; however, with regard to gender difference, the male students were predominantly from the Northern province of the country, whereas more females came from Karachi. After graduation, although the majority of the graduates began to work as staff nurses at AKUH, the retention was poor; moreover, it was poorer for male than female graduates. In general, several graduates have demonstrated progress in terms of upgrading their education and their career progression. Although a quarter of the graduates, both male and female (25% and 23%), have migrated abroad, at least 66% are actively contributing to the nursing working force in Pakistan in a variety of roles, but mainly as staff nurses and nurse teachers.

## Sample Demographics

As noted earlier in Chapter Three, a total of 24 key informants—16 BScN graduates and 8 supervisors—participated in this study. Among the graduates, 12 were female and four were male, whereas all of the supervisors were female. Further details on the informants are presented below.

### *The Graduates*

Of the 16 graduates, 2 were from the class of 2001; 3 each from the classes of 2002, 2003, and 2004; and 5 from the class of 2005. Hence, at the time participation in this study, their work experience ranged from four and a half years to five months. At the current time, 10 were working at AKUH, three were working at AKU-SON, and three were working at non-AKU institutions in the province of Sindh-Pakistan. However, all five graduates who were not working at AKUH had one to three years of work experience at AKUH before they transferred to AKU-SON or resigned from AKUH. Nurses in this sample worked on a variety of units/wards at AKUH, including medical and surgical, intensive care (ICU), cardiac intensive care (CICU), pediatric and obstetric, emergency room, and recovery room. In terms of roles and responsibilities, one had left the profession, five had a teaching role, and the rest were working as staff nurses. Their ages ranged from 22 to 27 years, with an average of 25 years. Only four of the female graduates were married and had one or two children, and the rest were single.

### *The Supervisors*

Of the eight supervisors, at the time of their interviews three were working as head nurses, and two as clinical nurse instructors cum acting head nurses on their units, whereas the other three of the supervisors were nurse managers who were responsible for more than one unit. Hence, like the graduates, these supervisors came from a wide variety of work areas at AKUH. In terms of their professional preparation, five had a post-RN BScN degree, one had a BScN degree, and two had a general three-year diploma from AKU-SON. Their work experience ranged from 4.5 to 17 years. Their ages ranged from 29 to 40 years, with an average of 33 years. Three were single, and five were married and had one or two children.

## Description of the Units

As described earlier in Chapter Three, I used participant observation to augment and elucidate the information that I gathered from the interviews. Following the unit selection criteria, I chose two units at AKUH for this purpose, and I refer to them as the North and South units. The North unit is one of the major inpatient units at AKUH, with a capacity for 58 patients. Although these units—such as medical, surgical, obstetrics/ gynaecology, or paediatrics—differ in terms of their patient population, their structure and staffing patterns are the same. For example, all of the major units have four types of beds with the same structure such as working or office space for the unit staff, which I explain below in the description of the North unit. Likewise, the South unit, one of the critical care units, differs from the other critical care units at AKUH with regard to the number of beds, but is similar in terms of patient acuity and staffing patterns. In this section I present an overview of these units and describe the unit structure and facilities, staffing, key functions and organization of work. Although most of the field notes on the interactions of staff on these units that I wrote as a participant observer are integrated with the interview data in subsequent chapters, I have assimilated some of my field notes in this section to explain the unit context. *PO* refers to *participant observation.*

### *The North Unit*

#### *Structure and Facilities*

The North unit is a 58-bed medical unit for adult patients of both genders. It has an average of 50-55 patients, or an 81%-87% occupancy rate. On average, 17-18 patients are admitted and discharged from the unit every day. Most patients on this unit belong to various subspecialties of medicine, including gastrology, pulmonology, urology, and nephrology. However, patients from other subspecialties, such as cardiology or oncology, may be temporarily admitted to this unit if those areas have no vacant beds. About 74% of the patients on the North unit are categorized as "high dependent."

The ward has four types of patient rooms/beds: semiprivate rooms, isolation rooms, special care beds, and general beds. The nursing station or unit reception is located in the middle of the unit and is manned by one or two unit receptionists around the clock. With the exception of seven semiprivate rooms and two isolation rooms, the unit is divided into blocks or bays to accommodate five patients in each. Patients are kept in these bays according to the subspecialty—such as gastrology—and gender. With the exception of special care, these bays have an open front, but the beds are separated by ceiling curtains. Each bay has a small counter with a wash basin, some storage space, and a plain surface area that may be used to work on patients' documents such as records of vital signs and Kardex files. Two of these bays, known as special care units are almost like mini units within the North unit, as they have a confined structure with a door at the entrance. Moreover, these units have separate structural facilities such as a washroom, as well as functional facilities such as a telephone and computer terminal. These units are equipped with better patient monitoring facilities, including a crash cart. In other words, special care units function like a mini ICU within the big unit.

In addition to the patients' blocks, the unit has various structures for staff function and teaching/learning activities, such as offices for the head nurse and unit coordinator, a staff lounge, seminar and conference rooms, and clean- and soiled-laundry rooms. The nursing staff predominantly use the staff lounge, the medical staff use mainly the seminar room, and all staff and students have access to the conference room on the unit. In a large multipurpose room at the back of the nursing counter, patients' medications are prepared. Staff lockers and a refrigerator are also found in that room. Some clean equipment such as oxygen flow meters and clean linens are also stored in that room. Likewise, a small area between the two special care units is designated for patients' visitors. With the exception of patients in special care, each is allowed to have one attendant—usually a family member—around the clock. Each patient's family members are issued two visiting cards for this purpose and must display them to the security guard at the entrance for access to the unit during nonvisiting hours. However, more than one person is permitted to visit patients during visiting hours in the evenings and on weekends.

Because AKUH is a private health care facility, patients are charged directly for all of the services and supplies that they receive. Although some services such as linen, food, and nursing include room/bed charges, others such as physician or physiotherapist visits, medicines, and medical surgical supplies are charged for according to the individual patient's needs. Drugs and fluids provided through physicians' orders are entered in a computerized system known as the Physician Order Entry. With the exception of stat doses and/or in case of new admissions, pharmacy staff deliver to the medication nurse on the unit a 24-hour supply of medicines and fluids for each patient at a designated time. A pharmacy outlet is located near the unit entrance, on the outside. A storage or distribution center for medical/surgical supplies (catheters, masks, syringes, hygiene care material, and sterile procedure packs) is located between the North and another major unit adjacent to it. This center is manned 24 hours a day by the material management department to provide medical/surgical supplies to the two major units (with 58 beds) on that floor.

The center staff or attendant has a computer terminal which keeps him informed on the patients currently on each unit, including their names and medical record numbers. To obtain an item from the center, members of the health care team must display their identity card to the center attendant and request the needed item with the name of the patient and his/her medical record number. The center attendant then enters the item in a record book and asks the staff to sign for it. Depending on the location of the patient on the unit and the availability of the center attendant, it may take 5 to 10 minutes to receive supplies from the storage area. Although the patients each have a separate bedside locker to store their supplies, staff are cautioned not to store any other than those for their immediate needs, which I learned in a staff meeting on the unit:

> The head nurse informed her staff about the audit of their unit that was conducted on the previous day. She shared the auditor's observation about the potential misuse of supplies that were found in patients' bedside lockers. She advised her staff to be cautious about what they issue from the distribution center and keep them at the patients' bedside because excess supplies other than the immediate needs may be misused inadvertently and have cost implications for the individual patients. (PO, May 17, 2007)

To expedite care on the special care unit, some urgent-care supplies are stored on the unit that may be used when needed and then replenished at a later point from the distribution center. The same procedure is used to refill the crash cart or stock medicine when it is used in an urgent situation. It is the responsibility of the nursing staff, usually the team leader, on the unit to ensure that every item used from the stock drugs or crash cart is replaced before the end of his/her shift. If something is lost or damaged, the team leader is held accountable, as Anum, one of participants, explained in her interview:

> If the medication stock is incomplete, it is the TL's [team leader's] or assigned nurse's responsibility to complete it. If you have not used it and someone else did it without telling you, you will have to search around and check with other nurses on who has used it; and if you can't find out, then you have to pay for it. Otherwise, an incident form will be filled out because you were responsible and you were not careful about it. [As a TL,] it happened with me once that I broke something by accident as I was checking the emergency kit. An injection fell and broke because the kit wasn't closed properly, so I had to pay for it. It was expensive, more than 300 rupees. However, I learned a lesson; now I am more careful in my handling.

It is worth mentioning that when AKUH was commissioned in 1985, the staff's accountability for hospital property (equipment, drug, or supplies) was not as extensive as it is now. Over the past few years theft of hospital supplies, including medicine and equipment such as glucometers, torches, or ophthalmoscopes, have continued to increase, which has led to stricter policies to resolve the issue. However, it is an extra pressure for nursing staff in addition to being accountable for various issues other than patient care. At times it also affects the staff's interpersonal relationships, as reflected in the following field notes:

> One female nurse said to a male staff, "I will not take over. You need to complete the stock; injection maxolon is missing." The male staff responded, "It has been missing for so many days." She replied, "Why did you accept an incomplete stock? What if the night in charge asks for it? What will I then do? So you'd better complete that!" After saying this, she banged the stock key and some papers on the counter down in front of the male staff who was sitting on a chair and searching for something on the computer. (PO, April 7, 2006)

In addition to the staff's interpersonal relationships, patient-care efficiency is also affected in the attempt to guard equipment/supplies that are needed for patient care. For example, items that are used frequently, such as glucometers, are kept under lock and key; and staff members must find the person who is carrying the key. Staff who want to use the glucometer may have to give up their identity card to ensure that they return the equipment safely to the person who is responsible for it.

### *Characteristics of Unit Staffing*

In April 2006 the nursing staff on the unit consisted of 30 registered nurses (RNs), including a head nurse (HN) and a clinical nurse teacher (CNI); 8 critical care technicians (CCTs); 19 nursing assistants (NAs); and 6 unit receptionists (URs). In terms of gender, the majority (87%) of the RNs were female, but all CCTs and most of the NAs and URs were male. Hence, the overall ratio of male to female staff was almost equal—49%:51%, respectively. Nurses, CCTs, and NAs provide direct patient care, and the URs are responsible for mainly the clerical functions of the unit such as answering phone calls and personnel inquiries and monitoring the nurses' call-bell system.

A red light on the wall at the patient's head indicates that a patient's call bell is on. On the nurses' call system at the unit counter in the reception area, the light flashes on the corresponding bed number and makes a soft beeping sound. The UR on duty has a staff assignment sheet, and if the patient is not attended to within a minute, the UR pages the assigned staff on the intercom. The intercom is also used to locate people on the unit for other purposes, such as to answer a phone call or meet a person at the counter. Incoming phone calls are not only for staff members, but also for patient visitors in the general bays. The intercom is turned off at 2200 hours to reduce the noise level on the unit during the night; however, during the day the unit is very noisy because of the high influx of people (unit staff, students, members of support services, patients, and visitors) as well as the frequent use of the paging.

All staff on the North unit were full-time employees (FTEs) who are supposed to work 45 hours a week. With the exception of the unit management staff—the HN, CNI, and services coordinator, whose office hours are 0700 to 1600 hours—all staff work in rotating shifts, usually two mornings, two evenings, and two nights per week. All shift employees at AKU are expected to work 45 hours per week and non-shift employees 42 hours. Each shift is 9 hours long with a 30-minute meal break and a 15-minute tea break. However, the meal break is unpaid; hence, the shift time is counted as 8.5 hours. Accordingly, the morning shift is from 0700 to 1600 hours, the evening shift is 1400 to 2300 hours, and the night shift is from 2230 to 0730 hours. There is a half-hour overlap between the evening and night and the night and morning shifts, whereas it is two hours between the morning and evening shifts. Hence, staff meetings and educational activities for staff development, whether on the unit or at the division level, are planned for this time.

With regard to professional education, of the 30 RNs, the HN and the CNI had a post-RN BScN degree, four staff nurses had a BScN degree, and the rest had a diploma in nursing. In other words, 80% (n = 24) of the nurses were diploma prepared, of which 17 (57%) were non-AKU-SON, and only 7 (43%) were AKU-SON graduates. Hence, the percentage of AKU-SON–prepared nurses was comparatively lower on the North unit than the overall percentage of AKU-SON–prepared nurses at AKUH: that is 71%. Unlike nurses, all of the other staff are hired after specific in-house training by the Nursing Education Service at AKUH. The CCTs are basically an upgraded level of NAs who are given additional training after some years of work experience at AKUH. Initially, this category of staff were trained to assist nurses on critical care units; however, currently, CCTs are assigned to almost all of the major inpatient units to help nurses with patient care.

In terms of the RNs' work experience, Table 3 shows that of the 30 nurses, 17 (60%) had less than two years of experience and that, of these 17, 10 (33%) had less than one year of experience. Of the remaining 13 nurses (40%), 8 had up to four years of experience, two had more than four years, and only three had more than six years, including the head nurse, who had about 10 years of experience. The other two staff nurses with more than six years of experience were diploma-prepared nurses from a school of nursing other than AKU-SON.

Table 3

*Nurses' Work Experience on the North Unit*

| Years of experience | Post-RN BScN | 4-year BScN | Diploma AKU-SON | Diploma Non-AKU | Total |
|---|---|---|---|---|---|
| <1 | 0 | 2 | 4 | 4 | 10 (33%) |
| 1-<2 | 0 | 1 | 0 | 6 | 7 (27%) |
| 2-<4 | 0 | 1 | 3 | 4 | 8 (23%) |
| 4-<6 | 1 | 0 | 0 | 1 | 2 (7%) |
| 6 to10 | 1 | 0 | 0 | 2 | 3 (10%) |
| Total | *2* | *4* | *7* | *17* | 30 (100%) |

***Organization of Work and Unit Management***

In general, the North unit used a mix of primary care and team nursing approaches to patient care. For example, in some blocks such as special care and the semiprivate area, one nurse along with a CCT or NA had been assigned to provide total care to their patients, including medications, whereas in other blocks a nurse or a CCT was assigned to take care of everything but medications.

The nurse-to-patient ratio in special care was 1:5, and 1:8-10 on the general unit; however, it ranged from 8 to 15 patients per nurse depending on the unit's census and staffing on a particular shift. According to the unit-budgeted positions, the unit was short of 6 staff nurses (28/34) and 12 CCTs (8/20). However, to compensate for the attrition of CCTs, the unit management had hired 10 more NAs against the budgeted position of the CCTs. Similarly, posts were available for assistant head nurses, but they were vacant. In addition, the unit had an absenteeism rate of about 3% with an average loss of three to four shifts per day; hence, almost every day the unit was short staffed despite the fact that one or two staff worked overtime or double shifts. For example:

> At the beginning of the evening shift, there were 51 patients. According to the staffing model of the North unit, there should have been at least 14 nursing staff on the evening shift, with a staff mix of 8 RNs, 4 CCTs, and 2 NAs, but there were 13 nursing staff on duty. Of the 13 staff, 7 were nurses, 1 was a CCT, and 5 were NAs. Of the 7 nurses, 1 was working as team leader and had a medication administration assignment for 30 patients, while the others had direct patient care assignments. Moreover, 1 of the RNs was working a double shift. Likewise, among the total staff, 1 CCT and 1 NA were trainees. Thus the staffing was short in terms of both numbers and quality. (PO, May 8, 2006)

Staff shortage was an apparent problem on the North unit that consumed a good portion of the nursing management's time to resolve the day-to-day staffing issues, as I wrote in the following notes:

> The HN and the night TL greeted at the counter. The HN began to look at the staff assignment sheet and asked the TL why staff A was asked to do a double instead of some other staff. Later I learned that staff A was a comparatively new graduate with about seven month's experience on the unit. The TL explained that he had no other choice. After checking the staffing schedule for the next 24 hrs, the HN instructed the UR to call one of the staff at home and tell her to work the night shift instead of the evening to cover for a staff member who worked a double shift yesterday. (May 16, 2006)
>
> Tonight, three RNs were absent without prior notification. The team leaders of the evening and night shift tried to call their head nurse to seek advice, but no one responded at her home number. They then tried the unit nurse manager. Meanwhile, two staff from the evening shift agreed to continue on the night shift but asked to be off for their scheduled evening shifts the next day. Since there was no other choice at that time, the manager approved this solution. One of the staff who agreed to do a double had a one-year-old child, and though she usually did

> not work night shifts because of her young child, considering the unit situation that night, she volunteered to work that shift.
>
> It was 2320 when the staff assignment was finalized with some adjustments, as they were still short one RN. After the shift change between the TLs, the night TL began to take over from the CCT for three blocks (15 patients) around 2340. So although the evening TL left at 2345 (45 minutes beyond her shift-end time), some of the other staff, including the night TL, were still busy taking over individual patients. (June 24, 2006)

In my conversations with the unit staff it was obvious that the constant staff shortage was distressing for both the unit staff and management. Moreover, it was creating tension between the staff and unit management, as I noted below:

> Batool, an out-stationed nurse, lamented, "We were told in the orientation that we have 23 working days as our earned leave each year, but it is difficult to have your earned leaves because of the staff shortage." She shared that she has asked for her accrued leaves to visit her family, but she was refused, though it had been a long time since she visited her family. I asked her, "You said the unit is short staffed, and why is it so?" She responded, "People don't stay here for long; they leave as soon as they have another opportunity." I asked, "Why do they leave?" She replied, "We do fulfill their [management's] expectations, but they don't do what we ask for. There is no appreciation for what we do. If there is no appreciation, at least they shouldn't discourage us." She added that "the salary is not so good, especially for those who are out-stationed and have to pay for their accommodation in hostel. A nursing assistant, listening to our conversation, looked at me and said, "Plus the double duties [a reason for the turnover]." The RN added, "We get tired in one shift but have to continue for another one, when there is no one to relieve us." (PO, June 24, 2006)

> I went to thank Aziz, who was one of the TLs on the North unit. During the conversation, Aziz told me that he had resigned recently and planned to go abroad. He is a non–AKU-SON diploma-prepared nurse. Upon inquiring, Aziz told me that, although he has learned a lot from working on the North unit, the job here has been very stressful for him . . . . He added that when he joined the unit, there were many senior nurses, but many of them had already left. For example, "I have no senior person on my shift. I am the only senior person in this shift, and my total experience is less than three years, though one should work as a TL with solid experience, but that is what we have." (PO, July 5, 2006)

All nursing staff on the unit report to the HN, who in turn reports to a nurse manager. Most of the nurse managers at AKUH oversee multiple units or areas and report to the Director of Nursing Services. In addition to this vertical reporting hierarchy among most of the nursing staff, the CNI and unit services coordinator work in lateral positions with the head nurse to assist her with the unit management, but they report to the unit nurse manager. Although the CNI was a nurse by profession, the unit services coordinator was not but had a business administration background and was responsible mainly for attending to patient care concerns pertinent to support services, such as pharmacy, diagnostic, and billing issues.

The head nurse was responsible primarily for the administrative work of the unit, and the CNI for staff development. Although some of their responsibilities were distinct—for example, the HN set the staff duty schedule, approved leaves, and conducted the performance appraisals; and the CNI was responsible for certifying the staff's psychomotor skills and planning the educational activities—there was some overlap between their roles in that both addressed patient-care issues and were involved in staff monitoring. For example, it was common practice for the CNI and the HN to divide the unit into halves and attend patient care report along with the bedside nurses from the night staff assigned in each bay. In addition, the CNI and HN covered for each other if one was on leave. Although the process of patient handover (patient care report) mainly involved communication about patient status and progress between the staff, it also served as a strategy for the CNI and HN to assess and monitor staff competence, as noted in the following observation:

> After a short meeting with the incoming staff for the morning shift, the HN and CNI began to take over from the night staff in different blocks of the unit. The HN started taking over from an RN, Rabia, who had been on duty for over 17 hours because she had had a double shift—evening plus night. Along with a male nursing assistant, Rabia was responsible for the total care, including medication administration, of 13 patients in the semiprivate rooms. After an exchange of greetings, the HN thanked Rabia for doing a double shift.
>
> During the shift change, the HN was standing by a table with all of the patients' files on it, while Rabia and the RN on the morning shift, Itrat, were sitting on chairs facing each other. Rabia was using patients' Kardex to report on the patient current status and nursing care needs. Itrat had a piece of paper and pen to take notes. The HN also had a unit census with some key information for each patient—such as the patient's name, bed number, gender, diagnosis, physician—and some space for important notes. As Rabia was giving an update on her patients, the HN was going through each file and checking the accuracy of the documentation in various forms used for records of patient care, including patient assessment, intake-output, drug administration, patient teaching, and so on, as well as asking Rabia pertinent questions. Accordingly, the HN was also jotting down some information on her census sheets. During this process Itrat was

> also interacting with Rabia and the HN besides taking notes. Overall, about 20 times the HN pointed out to Rabia some incomplete documentation, such as a missing entry or initials, etc. She also identified a wrong entry in the drug administration sheet: An insulin injection that was given last night was marked for tonight. In some cases the patients had received more fluid or less fluid than the prescribed rate. The HN kept questioning Rabia in a concerned but soft voice. Many times the HN said to her, "Please complete this" or "Correct this." One patient had a high fever, and the HN asked Rabia whether she had done anything about it. Rabia said that the NA had recorded the temperature and that she hadn't known until now. The HN questioned, "Aren't you supposed to read the patient's file?" and then instructed her to give the patient Calpol [an antipyretic drug] in consultation with the patient's on-call resident.
>
> It took about 30 to 35 minutes for the HN to take over the patients in the semiprivate rooms from the night staff. Even though it was a few minutes after 8:00 a.m., Rabia was required to complete certain things before concluding her shift. At one point during the observation, I felt that it must be discouraging for Rabia to have to go through such scrutiny of her documentation, especially because she had worked a double shift. However, looking at the number of inaccuracies that the HN had found, I thought to myself, How many things could she let go? If she doesn't demand that from the night staff, who will do this work? Attending the process of changing shifts enhanced my understanding of the high accountability in the system. (PO, May 16, 2006)

Although the CNI followed a similar process in taking over from the night staff and checked the accuracy of the documentation, she asked more questions to assess the staff's knowledge, such as, "Why is this drug given? Why is this procedure done? What complications can you expect with this diagnosis, or what should you watch for?" However, the shift-change process was not as meticulous between the nurses as it had been when the HN and CNI were there, as I note later in this section.

Case coordinators are another category of nurses who coordinate patient care. However, they are assigned to subdisciplines of medicine such as neurology and gastrology. They make patient rounds with the medical team and follow up on their orders with ward nurses as well as communicate with patient families. Hence, it is the case coordinator of the team and not the unit HN or TL who communicates with the physician or surgeon on a regular basis. As noted earlier, the HN, CNI, services coordinator, and case coordinators work office hours, after which the TL on the shift is expected to manage staffing and patient-care issues in their absence. In addition to unit-management responsibilities, most of the time, but not always, the TL is assigned medication administration for up to 30 patients.

***Work environment and work relations***. Some participants in this study described their work environment on large units as "chaotic and stressful." For example Areeb, a secondary informant, said, "The atmosphere on the unit used to get very noisy, especially during the handover time." Likewise, one participant commented on the lack of concentration due to high noise level and possible relationship with the frequency of drug errors on the unit. My observation on the North unit helped me to understand Areeb's description of chaos, as I recorded in my field notes:

> I accompanied one of the staff to observe the process of shift change between two nurses on morning and evening shifts. The nurse on the morning shift was referring to the information in the patient's Kardex, while the incoming nurse was making some notes about each patient on a paper. Unlike her HN or CNI, she was not looking through each file to see if the documentation was complete or not. The nurses were friendly in their interactions with each other. However, it appeared difficult for them to concentrate on their activity because of the loud and constant paging on the intercom for various members of the health care team. I kept drawing a line in my notebook with each page, and when I counted them, there had been 46 pages within about 30 minutes, so 1-2 pages every minute. Four times the page was for the staff nurse who was giving patient report, which consequently interrupted her conversation with her colleague. Apart from paging, the activity of patient report was interrupted by patients' relatives, the medical staff, and other nursing staff.
>
> One of the patient attendants said, "I am still waiting for my father's dressing." The nurse responded, "I have left messages for the concerned doctor several times, and I am told she is busy." When the patient attendant went into her room, the nurse said to her colleague, "I have called for this doctor [resident] about 10 times, but she is not responding."
>
> After a few minutes, a female member of the medical team, wearing a white gown and a stethoscope around her neck, approached these nurses from a certain distance and said, "Can you get some gauze pieces for me?" The nurse from the morning shift asked her, "Are you doctor so-and-so?" She responded affirmatively. The nurse stated, "Why were you not responding to my calls?" The doctor responded, "I was busy with other things" and turned to walk towards the patient's room without making eye contact with the nurse. The nurse commented, "It is the patient who suffers"; the resident entered the patient's room saying, "It is okay." As the shift-change activity continued, a patient attendant's mobile phone started ringing as she said to the nurses, "Please remove my mother's cannula." (PO, June 24, 2006)

On many occasions in the work environment it was evident that a good portion of nurses' time is spent on coordinating patient-care activities with members of the medical team.

For example, in addition to the above dialogue on a patient's dressing, at one point in the process of shift report, the morning nurse informed her colleague:

> Mrs. A is supposed to have an ultrasound. She was told to keep her bladder full, but she forgot and went to void. Now her bladder is full, and she is waiting for ultrasound, but no doctor is available for the procedure now, though I have checked twice for this. (PO, June 24, 2006)

Although in general the staff had friendly working relationships among themselves, the nurse-physician or nurse- doctor relationship was not cordial. *Doctor* is a generic word used for medical staff of all levels, such as interns, residents, and consultants, whereas in the context of AKUH, the word *physician* is mainly used for consultants. Nurses and doctors work within their own hierarchies; however, they talk to each other when necessary. Physicians along with their teams, including students, resident, and case coordinator came for patient rounds at any time of their convenience, it is not necessary for the bedside nurse to be present in the round; however, he/she is usually informed about the changes in the patient care regimen through the team resident or case coordinator as well as the written orders in patient file.

Most, but not all, staff were not happy with their unit management, as noted earlier in this section. Some of them expressed differential treatment by the management:

> Ishrat was the last staff who came for a tea break in the nurses' lounge. The staff asked me, "How is your research going" I responded, "Quite well." The staff asked, "How do you find this unit?" I said, "People are very helpful and friendly." In response the staff said, "Did you notice, nobody is happy here, there is a lot of grouping. Management favors certain people." The staff shared a personal example to explain the differential treatment among staff by the management and then commented, "We are not even working at a level of ISO 2000 [an accreditation for quality], but now we are going for JCIA [Joint Commission of International Accreditation]. What is the use of this? It is a false reassurance, but to what end? The entire focus is on accuracy of documentation, but not what the staff go through. . . . The environment in hospital X is not stressful. Nurses don't cry there. Here, I have seen nurses crying when they are bullied. I asked the staff, "What keeps you going here?" and the response was, "I need money, everyone working here needs money including the HN. It was interesting to see the HN there when I went for an interview by a foreign recruitment team; she was also there for an interview." (PO, June 24, 2006)

My observation indicated that collaboration between the HN and the AKU-SON faculty was almost nonexistent, as described below:

> There was no greeting between the HN and a faculty member who along with her students came to join the shift report. I thought they may have had an interaction already, but at a later point when I asked the HN, she confirmed that it was the first time that they had seen each other this morning. The HN added, "Sometimes even I don't know the name of AKU-SON faculty members. The tradition of faculty introducing and interacting with the HN and the students is not there any more. Sometimes when I ask the students for something, they ask me, 'Who are you?'" (PO, May 10, 2006)

> The North unit was short of staff on the morning shift. After making some adjustment to the staff assignment, they needed a male nursing assistant to help the female staff nurse in the semiprivate area (11 patients of both genders). Hence the HN asked the UR to call the unit nurse manager and request that a male NA from another unit be sent to help, but apparently it was not possible. Since I had seen a number of male nursing students on the unit and two nursing instructors from AKU-SON, I asked the HN, "Do you think you will get some help from the male nursing students?" Initially, she was reluctant but then decided to approach one of the instructors and asked if some of her students would work in the semiprivate rooms. Her first response was, "They [students] have their own objectives," but then she said, "Let me look into this." Later, she assigned two male students to the area.
>
> I wonder whether this instructor would have helped the HN had I not been there on the scene because I had been her director in the past. Although I didn't ask her on behalf of the head nurse, my presence still might have influenced her response. (PO, May 16, 2006)

## *The South Unit*

### *Structure and Facilities*

The South unit is a 14-bed critical care unit for adult and pediatric patients. About 45%-50% of the patients are usually very sick with multi-organ failure and require strict isolation, and most of the patients on this unit are usually on mechanical ventilation. The unit is equipped with lots of high tech equipment.

Entry to the South unit is fairly controlled through double doors and a security guard who watches who enters and who leaves the unit. Patient visitors must carry a card that is issued to them upon the patient's admission to the unit. As one enters through the first door of the unit, there is a small room on the right for patients' families that is equipped with a few chairs and a table. Next to that is the second entrance to the unit, which is a glass door that is kept locked all the time. The ICU receptionist inside the unit may open the door through an intercom system or by a person through the use of a code from outside.

The South unit is oval shaped and has two small counters at each end. Counters are located at the center of the unit, with patients' rooms/bays and other structures around it. Both counters have a plain surface area and storage space where all kind of forms are kept for easy access. A phone and a computer terminal are also available on both counters. The UR is seated at the first counter, which is close to the unit's main entrance.

As one enters the unit, on the left side is a soiled-laundry room, and adjacent to that is a small staff lounge that is usually used for tea or meal breaks, but also for educational purposes. Next to the lounge is a clean utility room with medical/surgical supplies, including sterile procedures packs, and clean linen. This storage area is manned by material-management personnel around the clock to provide supplies and maintain records following the same system that the North unit uses. However, this area is exclusively for patients on this unit to allow the staff to obtain what they need quickly. Moreover, in the South unit, all items that are used frequently such as syringes are kept in a handy pack at the patient's bedside. To obtain medicine from the pharmacy, the same system is followed as described in the North unit. However, the unit has a good stock of intravenous fluids and emergency medicine, in addition to crash carts. The staff use stock medicines when needed and replace them later when they receive the particular items from the pharmacy.

Next to the clean utility room is a large bay with various equipment and machines such as spare ventilators and beds, and the machines are usually cleaned and disinfected here. This bay is also used for staff teaching that involves demonstrations, such as mock drills. In total there are 11 rooms or patient bays, some with an open front and others with a closed front and a door. The two large bays have the capacity for two or three patients, whereas the others have single beds. The unit has two small offices, one for the HN and CNI and the other for the physician, but it is used mainly by the anesthesia resident assigned to the unit.

Overall, the South unit seems overcrowded with people and machines. It has very few chairs, but a separate overhead moving table in front of each patient's bay or room is used for the patient's flow sheet for documentation. In addition, two fridges (for medication and patient feeds), crash carts, intubation trolleys, and a stocks drugs cart are in view. People usually stand, whether they are talking or writing notes. Patients' visitors—family members or friends—frequently pay short visits; they usually come in, stand near the patient for a few minutes, and leave the unit. Although the patients' visitors may interact with the nurses or physicians at the bedside, usually they have very little interaction with the unit staff, including the nurses and physicians.

***Characteristics of Unit Staffing***

In May 2006 the unit had a total of 76 staff, including 48 RNs, 12 CCTs, 10 NAs, and 6 URs. Of the 48 nurses, only 10 (21%) were male, whereas all of the CCTs and NAs were male, and all but 1 UR was female. Hence, in terms of gender mix, the proportion of male to female was almost equal among the nursing staff on the unit. Unlike on the North unit, where nurses and CCTs wear different uniforms, on the South unit they wear green-colored scrub suits. Most of the staff hang their identity cards around their necks. The head nurse and CNI wear white uniforms because they may leave the unit to attend meetings or conduct audits on other units. The physicians and unit clerks do not wear uniforms, but dress formally. However, the anesthesia residents who work on the South unit and in the operating room wear blue scrub suits.

Of the 48 RNs on the unit, 45 were working as either critical care nurses (CCRNs) or staff nurses, 1 as a CNI, and 2 as assistant head nurses. One of the assistant head nurse (AHN) was working as an acting head nurse. In terms of the nurses' professional qualifications, two had post-RN BScNs and 9 had BScN degrees, and the rest had general nursing diplomas. Of the diploma-prepared nurses, 13 were non–AKU-SON. Accordingly, the proportion of degree and diploma nurses was 23% and 77%, respectively, and of the 48 nurses, unlike on the North unit, the majority (73%) were AKU-SON graduates. Of the two post-RN BScNs, one was the CNI and the other was an assistant head nurse; however, the acting head nurse was a diploma-prepared nurse.

In terms of the nurses' work experience on the South unit, Table 4 shows that 51% (n= 24) had less than 1 year of experience, 21% (n=10) had 1 to 2 years of experience, 19% (n = 09) had 2.5 to 4 years of experience, and only 8% had more than four years of experience. Both the CNI and the AHN on the unit had about 4.5 years of experience. The CNI of the unit is highly respected among her staff for her clinical knowledge; she is the only nurse on the unit who is involved in multidisciplinary research as Co- principal investigator with physicians.

Table 4

*Nurses' Work Experience on the South Unit*

| Years of experience | Post-RN BScN | 4-year BScN | Diploma AKU-SON | Diploma non-AKU | Total |
|---|---|---|---|---|---|
| <1 | 0 | 5 | 10 | 9 | 24 (51%) |
| 1-<2 | 0 | 3 | 7 | 0 | 10 (22%) |
| 2-<4 | 0 | 1 | 5 | 3 | 9 (19%) |
| 4-<6 | 1 | 0 | 1 | 0 | 2 (4%) |
| 6 to 10 | 1 | 0 | 0 | 1 | 2 (4%) |
| Total | *2* | *9* | *22* | *16* | 47 (100%) |

### *Organization of Work and Unit Management*

As on the North unit, all nursing staff report to the head nurse, who in turn reports to the unit nurse manager. The CNI on the unit is responsible mainly for staff orientation and continuous staff-development activities. Likewise, she is responsible for monitoring the quality of patient care on her unit and also participates in the external audit for the same purpose. In addition, she shares some of the head nurse's work on a daily basis, which is similar to my earlier description in this section of the overlap of the work of the HN and CNI on the North unit.

Unlike on the North unit, NAs are not expected to deliver direct patient care but are responsible mainly for the inventory and care of the equipment, and they run errands to the pharmacy and laboratory and help nurses to take patients to other units or departments such as diagnostic services. In terms of staff mix, there are at least 10 nurses to 4 CCTs or 11 nurses to 3 CCTs on each shift. The nurse-patient ratio is 1:1-2. Like nurses, CCTs are assigned to individual patient care; however, they are not permitted to administer medications, which the nurses do. With this exception, the South unit takes a primary nursing approach to patient care.

Besides patient care assignment, most nurses have special assignments such as stock replenishment, narcotics inventory, crash-cart inventory, or glucometer care. Usually a TL works on each shift as a designee for the HN. The TL is responsible for ward administration in general and may or may not have an individual patient care assignment.

As on the North unit, all of the staff members on the South unit are full-time employees. Similarly, with the exception of the CNI and the AHN, the staff work on rotating shifts for a total of 45 hours per week. However, similarly to the North unit, this unit also faced the issue of double shifts and overtime, as indicated in the following observation:

> Looking at the staff assignment sheet, I asked Bano, the team leader, "So two of your staff are doing double today?" She looked at me for a few seconds with a somewhat frustrating look and then said, "Hmm, today only! *Roz ka masla hay* [It is a daily problem]." (PO, April 26, 2006)

Although the South unit had enough staff to care for 14 patients, it did not have enough people to cover leaves; furthermore, the unit had an absenteeism rate of about 4%. In addition, a number of staff had been released from the unit for continuous inservice education to meet the standards of staff professional development. Plus some of the staff were in their orientation and were buddied with experienced staff instead of having an independent patient assignment. Consequently, on average, one or two nurses worked overtime on each shift.

***Work Environment and Work Relations***

In general, the staff members were apparently very helpful to each other. However, many of them stated that they found it challenging or stressful to cope with the demands of their work environment. With regards to the nurse-physician relationship, nurses, particularly the TL had had close interaction with the anesthesia resident. However, in terms of interaction between the bedside nurses and patient consultant of different sub-disciplines was usually very formal and not cordial. Some specific observations about the nurse-physician relationship are incorporated with the interviews data in the subsequent chapters.

As on the North unit, the staff were usually not relieved until 40 to 45 minutes after the scheduled completion of their shifts; this issue was more prevalent on the morning shift. For example, the overlap between the night and morning shift is expected to occur from 0700 to 0730, but the CNI and HN's bed to bed report from the night staff were usually not completed until 0830. Overall, there were many similarities in the work environment between the North and South units with regard to staff shortage, working relationships between staff and management, and accountability for patient care. However, there were differences in terms of patient acuity and nurse-patient ratio.

### *Summary*

In this chapter I have presented the demographic information of the first five cohorts of BScN graduates from AKU-SON over the period 2001-2005 and have explained the demographics of the sample—the key informants in this study. Likewise, I have described the two inpatient units at AKUH where I conducted my observations to gain an understanding of the nurses' work environment and to substantiate the information that I gathered through the interviews.

# CHAPTER FIVE:

# FINDINGS: THE GRADUATES' EXPERIENCES AND PERCEPTIONS

This chapter presents the analysis of the data, mainly with respect to the questions that I asked all of the BScN graduate informants in this study. However, where appropriate, I have also integrated comments from some secondary informants as well as the information that I obtained from my participant observation. In total, I asked 20 questions, excluding the probes, of all of the informants in the graduate category (Appendix F). I have organized these questions and the responses into 11 sections that represent different topics. Hence, each section contains responses to one or more questions. Accordingly, these sections are characteristics of competence, the experience of being a BScN graduate, the experience of transition from student to staff role, perception of roles and responsibilities, graduates' role preparedness, graduates' strengths and challenges, application of teaching and research knowledge, perception of nursing, perception of the BScN program, future aspirations of the BScN graduates, and suggestions for the BScN program improvement.

Depending on the nature of questions and the elicited data, in some sections I treated each question as one category; in other sections, I grouped the informants' responses in more than one category for a single question. Each section is followed by a summative account for all the categories in that section. Usually, I have identified the informants' quotes by their pseudonyms; however, in some places, I avoided use of the pseudonyms to further protect the individual's identity. Similarly, a sign of ### has been inserted to replace a name or word that might have risked participant identity.

## Characteristics of Competence

To identify the characteristics of competence in nursing practice and the perception of the effectiveness of a nurse's role, I asked all of the graduates two questions: "What characteristics/attributes are needed to be viewed as a competent nurse on your unit?" and "How would you describe a successful nurse?" In response, the informants alluded to various elements of competence that are required for them to be considered competent and successful as a nurse. Although in general the graduates identified similar elements of competence in response to both questions, there were some subtle differences with respect to their emphasis of certain aspects. For example, they offered more comments and elaboration on the required professional development ability to be a successful nurse compared with the required abilities to be considered a competent nurse on the unit. Considering the overlap of the responses, I portray the informants' responses to both questions in two categories: knowledge and skills; and attitudes, values, and behaviours. However, to illustrate the subtle differences in their responses, I have also included subcategories for each question: the attributes of competence in nursing practice and the attributes of a successful nurse.

### *Knowledge and Skills*

This category consists of the informants' comments on professional knowledge and skills. In this context the term *skills* is not limited to psychomotor skills, but includes cognitive skills such as judgment ability, critical thinking, problem-solving, and decision-making, as well as communication and interpersonal skills that are considered necessary for nursing professionals. However, in the informants' narratives the term *skills* without an adjective usually refers to psychomotor skills in nursing practice.

#### *Attributes of Competence in Nursing Practice*

With regard to the attributes or characteristics required to be viewed as a competent nurse, all of the informants, whether explicitly or implicitly, referred to professional knowledge in areas such as human physiology, pharmacology, and nursing processes as one of the key factors. Although the majority of the informants stressed the importance of psychomotor and/or technical skills, they also alluded to cognitive and communication/interpersonal skills that are required for safe, and effective patient care. Moreover, they identified some personal characteristics, such as confidence, creativity, vigilance, promptness, and emotional stability to manage patient care efficiently.

Diya responded that to be considered competent, nurses need to have "good knowledge, skills, and attitude, plus problem-solving and communication abilities and planning and organizational skills." Bahaar mentioned "good observational skills, and the ability to provide safe patient care." Anum replied that on her unit the required attributes are "good theoretical knowledge, critical thinking, competence in basic nursing skills, and alertness and promptness. It is also preferred that the nurse be confident and assertive in doing the right things." Likewise, Hirah stated that on her unit a nurse's competence is assessed on his or her abilities of "critical thinking, decisions making, and creativity in managing patient care, as well as communication and interpersonal skills—how the nurse communicates with the patients and her colleagues."

To be regarded as a competent nurse, Kanwal and Kiren identified similar abilities to those that other participants mentioned; in addition, they elaborated on the types of communication skills that are required. Kiren asserted:

> First is psychomotor skills; it is very important. Then promptness, prioritization of patient care needs, and quick decision-making ability. Communication and interpersonal skills are also very important, especially the ability to stay calm while handling the patient and family, who are usually very anxious and require immediate attention.

Likewise, Kanwal replied:

> Whoever is very confident, serious, and speedy in her work and has knowledge as well. On our unit, the speed at which nurses work and their ability to work without mistakes [to provide safe care] matters a lot. Also, a nurse who is good in communication and always smiling. Some nurses may cry when they have a tough time on the unit, and such weak self-control is not appreciated. Those people who talk a lot or joke around or don't appear serious in their work are also not appreciated . . . . We smile at each other [the staff] a lot, but by serious I mean not talking unnecessarily and not joking all the time. When you are working in patient care areas, you have to be watchful about your words and gestures.

In Daud's opinion, nurses who are able to manage crisis situations effectively would be considered competent, in addition to those who could have effective communication skills:

> A competent nurse has the ability to deal with crisis situations effectively, in addition to routine patient care skills; one who is vigilant, has the ability to think critically, make decisions quickly, and manage time efficiently; and one who has effective communication skills, who can explain things to patients and families in a manner that eases their anxiety and/or satisfies them.

In addition to other attributes, Adil emphasized the listening ability of nurses:

> For a competent nurse on our unit, you should be knowledgeable, particularly have sound pharmacology knowledge, and be competent in psychomotor skills.

> You should be a good observer and have the ability to assess the patient's condition and evaluate the outcomes of the intervention or treatment that the patient is receiving. You should have good communication skills, including good listening ability, while interacting with your patients.

Like Adil, Bilal and Deeba suggested that sound pharmacology knowledge is also necessary to be viewed as competent. Bilal replied that "safety of the patient is one factor. But besides that, it's theoretical knowledge, including physiology and sound pharmacology knowledge, which is a must. Problem-solving and decision-making ability, technical knowledge, and psychomotor skills are also required." Likewise, Deeba reported:

> On my unit you need to know your basics of pharmacology, your basics of nursing theory, your basics of nursing care. And then your hands-on skills are important because you are asked to do things very quickly, and you are allowed a very minimal chance to do things wrong because it is a matter of the patient's life, so you need to have good hands-on skills and time-management ability.

Like many other participants, Komal also considered managing patient care with efficiency as a requirement:

> On my unit a nurse is considered competent if she is quick and able to manage her time efficiently. She knows how to tackle different patient care situations [solve problems], is very helpful towards others—colleagues and particularly the management staff—such as helping the head nurse or CNT [clinical nurse teacher] with arranging staff for a particular shift or assisting them in making staff schedule.

Although Komal implied that a good relationship with the unit management staff is important, Huma explicitly identified a "good relationship with management" as one of the personal attributes required of a nurse to be considered competent on his or her unit.

Aamna identified some additional abilities required to be considered competent from a patient care as well as unit management perspective:

> A nurse who is aware of the clients' rights, can identify clients' needs, communicate them properly to other members of the health care team, and guide the patients or fulfill the patients' needs accordingly; plus one who is a good leader, advisor, organizer, and a good team leader when managing a unit.

### *Attributes of a Successful Nurse*

Although the informants commented on various cognitive, interpersonal, and affective skills that are required to be successful as a nurse, the majority highlighted the importance of competence in patient-care skills, particularly psychomotor skills. For example, Kanwal thought, "A successful nurse is one who definitely has a lot of professional knowledge, who is very competent and very confident in her [psychomotor] skills, and who has good communication skills." From Daud's point of view, it is a nurse who has "cognitive and problem-solving abilities, who is prompt and confident and able to do things quickly within limited time." Likewise, Komal saw a successful nurse as "one who is knowledgeable, who has a command of his or her skills and knows how to tackle a situation, and who is very competent in time management." Kiren simply responded, "A nurse who is competent in her psychomotor skills," and Atya described a successful nurse as

> one who has a good knowledge, good interpersonal skills, and who is competent in psychomotor skills. In addition, one who has critical thinking abilities and who can apply that thinking in a real practice setting to solve or resolve issues that she encounters in her practice.

These excerpts clearly indicate that possessing certain knowledge or skills is a requirement to be successful, but it is not sufficient. Successful nurses must be able to apply theory to practice to fulfill their job responsibilities.

To Huma, a successful nurse is one who "has in-depth knowledge of his or her work area, one who is capable of dealing with patients' concerns and who can communicate well with patients and their family members." Huma also highlighted an interesting aspect of interpersonal relationships: "a good relationship with management." She explained how this makes a nurse successful: "I think it plays a key role. If she has a good interpersonal relationship with the management staff, then she can share her ideas and concerns. Through this, she can work freely without any fear of management." In other words, Huma was stressing the importance of interpersonal relationship for open communication.

Many of the graduates also viewed self-satisfaction with their work as a necessary factor to be a successful nurse. Some of the graduates talked about holistic care and related it to patients' and nurses' satisfaction; hence, they considered it important to the success of nurses. For example, Anum indicated that a successful nurse "is a person who is satisfied with his or her own work." Similarly, Huma asserted that "the most important thing is that the nurse should have job satisfaction." Diya identified a successful nurse as one

> who has knowledge plus competency in [psychomotor] skills. A nurse cannot be successful if she has a degree, but doesn't show competency in her skill performance. If you are not perfect or good at your skills, then that knowledge is of no worth. So for me, a successful nurse is one who can give holistic care to his or her patients and their families and who can handle any situation with success.

Aamna viewed a successful nurse as one "who is fulfilling her job requirements successfully, is able to take care of patients in a holistic manner, and is able to satisfy herself as well as the client." Adil, Hamid, and Hirah held similar views. To them, holistic care means "looking after all dimensions, . . . physical, social, physical, psychological, spiritual dimensions; not only dealing with . . . superficial physical care, but all aspects of care" (Hirah).

However, Aisha, Bahaar, and Bilal thought that to be successful, a nurse needs to have many other abilities and play multiple roles in addition to providing safe and competent patient care as a bedside nurse. For example, Bilal believed that a successful nurse is one "who is conscious of the patient's safety, who does not make mistakes, who is clinically competent, but who is also ambitious and involved in other activities, such as research and education activities." Similarly, Bahaar maintained:

> To me, a successful nurse is a person who is competent in all aspects—skilful and competent in patient care, but who is also able to perform other roles of a nurse: nurse as an advocate, as a counsellor, as a care agent, as an educator, and so on.

Aisha asserted that to be successful:

> You need to have many skills aside from being competent in psychomotor skills. One should have an all-round approach, have good interpersonal relationships, critical thinking, observation skills, and be able to continuously upgrade knowledge pertinent to one's work.

### *Attitudes, Values, and Behaviours*

This category includes the informants' comments on the values, attitudes, and other behaviours related to professional/work ethics that they considered important to be a professional nurse.

#### *Attributes of Competence in Nursing Practice*

With regard to the attributes or characteristics required to be considered a competent nurse, the informants commented on some specific values, attitudes, and behaviours. From Hamid's perspective, to be considered competent, a nurse must have a caring attitude in addition to theoretical knowledge and confidence in skills performance: "No one can really provide good care with only knowledge and skills if there is a lack of a caring attitude." Similarly, Deeba stated, "Another characteristic is a caring attitude towards patients and their family members because they are going through a bad period of their life." Aamna emphasized that a nurse needs to have a positive attitude toward nursing to be effective in his or her practice:

> I think that the nurse should accept her own profession. Once you are satisfied with your own profession and think that you owe care to your clients in a holistic manner, then you will have no difficulty in fulfilling a patient's needs, and hence being effective or competent in your practice.

A number of graduates identified various behavioural attributes related to professional/work ethics that they considered necessary to be viewed as competent on their units. For example, Huma suggested "a professional attitude with staff members, clients and their family," but offered no elaboration. Daud referred to "honesty in work and self-accountability. The nurse should do each and every thing, whatever he or she has learned [in professional education], because nobody can really watch over your work, but you should have self-accountability." Hirah explained the importance of self-accountability in ensuring patient safety:

> For example, if an incident happens or a medication error is made, the nurse should not hide it, but directly inform the concerned personnel so that appropriate action can be taken immediately. This is important for safe and ethical care.

Huma considered "regularity and punctuality in attendance at work" as important, and Hirah described the implications for patient care and the entire work environment when a nurse is not consistent in her attendance at work:

> Regularity and punctuality, that is very important. If a nurse is not regular in her work, then this disturbs the whole work environment, which is a major issue in our hospital. When a nurse doesn't report for her shift, another nurse is required to do a double shift to cover for that absenteeism and this nurse may already be tired after her own shift. Therefore, everyone is affected, the patients and the colleagues.

Adil noted, "Teamwork is important. One should be a team player, help and cooperate with colleagues." Likewise, Bahaar commented on similar behaviours that are required to be considered competent and explained the consequences when the spirit of teamwork is lacking:

> Willingness to manage a high workload or work hard to fulfill the unit management expectations, such as doing double duties and overtime to overcome the staff shortage . . . . For example, on our unit the staff were in dispute with their management because they thought their workload was too high, so usually they would not agree to do a double shift, but threatened to resign with twenty-four hours' notice if they were pressured to do a double shift. Hence, a junior staff member like me would always end up doing a double shift.

Although many graduates commented on professional development activities in their reflections on the attributes of a successful nurse, Aisha was the only graduate who suggested that a successful nurse needs to have the capacity for and a good attitude to learning to continuously upgrade his or her knowledge and skills and to remain competent in patient care.

### *Attributes of a Successful Nurse*

Five graduates considered a caring and helping attitude an important factor in being a successful nurse. Moreover, they stressed the necessity of a responsible and accountable attitude to avoid negligence in patient care. Deeba commented that a successful nurse is one "who has a caring attitude towards others—patients and their families, and colleagues." Likewise, Daud thought of "caring and commitment to work as the first mandatory characteristic for success." Diya asserted that a successful nurse "has a helping nature, good attitude and behaviour towards colleagues. Plus, if you are not motivated from inside to care for a patient, than it's of no value to do nursing as a job." To Kiren, a successful nurse is one who is able to follow her conscience and fulfill "all of the professional accountabilities and . . . responsibilities without negligence." Hamid emphasized the importance of regularity and punctuality in attendance at work in addition to a caring attitude towards patients.

Some graduates commented on professional growth and development as a necessary factor in professional success. For example, Diya described a successful nurse as "someone who has the enthusiasm and motivation to upgrade his or her professional knowledge and skills as well as to improve *self* as a person." Similarly, Kanwal identified a successful nurse as someone "who strives to get more education in nursing." Huma thought that "active participation in teaching/learning activities is necessary; for example, organizing or conducting a session according to staff needs or participating in other professional development activities, such as International Nurses Day or professional conferences or seminars." Although Aamna did not specify what needs to be achieved to improve that practice and how it might be achieved, she suggested that successful nurses are "looking towards the future for better options and better practice."

### *Summary*

The informants' accounts indicate that, in addition to professional knowledge and skills, various personal and interpersonal abilities are required to be considered competent in clinical practice. Although in general the graduates identified similar characteristics regardless of their work unit, there were some differences with respect to their emphasis on certain areas of knowledge. For example, according to graduates some units expect nurses to have more thorough pharmacological knowledge. However, almost every unit requires that nurses have good hands-on, problem-solving, and communication skills in addition to professional knowledge.

As expected, the participants identified similar attributes in response to my question on what is required to be considered competent and successful in nursing practice. As Atya accurately stated, "If a nurse is competent, then her characteristics will enable her to become a successful nurse as well. So competency will lead her to success."

The graduates identified similar attributes to describe *'a successful nurse'* and a *'competent nurse.'* For example, Deeba alluded to a caring attitude in answering both questions. Despite the similarities in the attributes that the graduates considered necessary to be a competent or successful nurse, there were also some subtle differences among the responses. For example, for some participants there was emphasis on nurses' promptness and time management to be considered competent. Many informants however, stressed the need for professional growth and development as a key factor in being viewed as a successful nurse. Some graduates explicitly stated that to become successful, nurses need to be clinically competent, but also participate in teaching and research-related activities. Finally, some suggested that successful nurses can achieve patient as well as self-satisfaction by providing safe and holistic care.

## The Experience of Being a BScN Graduate

After seeking their description of a successful nurse and the characteristics of competence, I asked all the graduates a grand-tour question: "What is it like to be a graduate of the BScN program in the work environment?" The purpose of this question was to elicit the graduates' views and feelings about themselves based on their experiences in the work environment. In response, the graduates reflected broadly on their experiences and perceptions of others in the work environment as well as in their families and in the community at large. Based on the acquired data, I broadly categorized the informants' narratives on the above question as recognition, challenges, and relationships. I then divided all of the positive experiences and perceptions associated with recognition of the graduates into two subcategories: appreciation, and rewards and opportunities. I subcategorized all accounts reflecting the graduates' challenges as expectations, and resistance and resentment.

### *Recognition*

This category consists of two subcategories: the informants' narratives about appreciation, and rewards and opportunities.

#### *Appreciation*

On the positive side, some graduates expressed a sense of appreciation based on their self-appraisal in the work environment or their experiences with supervisors and colleagues, including nursing and medical staff. Bahaar reflected:

> My BScN program has fully prepared me in all the ways, not only in regard to . . . communication skills or professional development, but in all the components,

> because we went through lots of challenges in our program, and those experiences collectively made me mentally prepared to know how to really work in the clinical setting . . . .There was much difference in my working and working of others, and that was quite revealing . . . . I was working according to the standards. ... Initially, for the first fifteen days I worked in the general block. My supervisors called me and they said, "We really appreciate your efforts, the way you are planning the group, teaching the mothers on baby bath and on the NG feeding, and different aspects of care." . . . They really appreciated me at that point in time, and they said, "We would like you to grow further," so they assigned me a higher level of responsibility, so first . . . as a medication nurse, and then in the special care unit, and then in the TL [team leader] role. ... In each and every shift I was getting very positive responses from the patients' attendants as well. Even they used to say, "Miss ABC has come, and it means that the whole shift will go smoothly. In a very good way, at least our voice will be heard [and our concerns will be addressed]."

Aisha did not see herself as different from the diploma-prepared nurses with regard to her psychomotor skills, but she felt proud of her theoretical knowledge:

> In practical [psychomotor skills], I was at the same novice level as diploma graduates were . . . . I was more prepared about research, and I was very good in my theory. So that theory portion helped me to move forward, and it distinguished me as a BScN graduate, different from the diploma graduates.

Huma said, "Sometimes I feel that that the BScN program made me assertive, vocal, and maybe overconfident." She then recalled how she had been treated by others—both positive and negative experiences. On the positive side she revealed:

> I feel proud when I am appreciated by healthcare workers about my work and decision-making in patient care and when they comment, "She is a BScN." I noticed that people accept my suggestions about patients' care more easily than the suggestions of diploma nurses.

Kanwal also appreciated the theoretical knowledge she acquired in the BScN program:

> There is a doctor who is assigned most of the time with me, so he keeps on asking things such as, . . . "What do we give when a patient's potassium is high?" So if I say, "Okay, this, this, this, this," he would be very impressed: "Oh, so you know it!" . . . Few days back, he was introducing me to some other doctors who are also interns, his colleagues. So he was saying, "*In se milay*" [a respectable manner of introducing another person]—"She is a very genius nurse." And I said, "Thank you, thank you, thank you!" [with actions and a smile] That was just a joke, but I really liked it. At the back of my mind I was happy—when you think that a nurse can be a genius!

Although Daud faced many difficulties because of his assertiveness, which I will describe later, his supervisors trusted him for his knowledge and appreciated his competence in patient care. He reported, "Most of them appreciated me. There was also a fellow [medical resident], and whenever I was assigned to his patients, he used to say, 'Daud is here, so we don't have to worry.'"

Diya noted that her colleagues acknowledge and admire her for her abilities and that they consult her about various things, such as medication regimens, diagnoses, tests, and so on:

> I have a certain respect level from them. Whether they are twenty-five, twenty-six years old, still they address me as *Aap* [respectful word for *you* in Urdu] instead of *Tum* [casual word for *you* in Urdu]. I tell them, "It is okay if you are using *Tum*," but they say, "You have studied a lot, so we feel a bit shy to address you as *Tum*."

It is important to mention that many of the nursing staff in Diya's unit are not registered nurses.

Some informants also alluded to the respect and appreciation that they enjoy in their family or community. For example, Hirah explained:

> They [her parents] feel proud that their daughter is a nurse. I also feel very proud in my community that I am a nurse, I am a BScN. In fact, wherever my husband goes, he introduces me as "Hirah is a BScN nurse." It is a matter of pride if you tell somebody that I am a BScN.
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> In the Ismaili community [sect of Muslims], there is full awareness about what a diploma program is and what a BScN program is, because every year in July, August, there is an announcement in our Jamat Khanas [Ismaili mosques] from the School of Nursing regarding these programs in which it is clearly explained that there are two programs in nursing . . . . They think that it is very difficult to get admission in BScN program; they also see that fewer people get admitted in the BScN program. They know that one should be having a certain percentage and aptitude to get enrolled in the BScN. They know that the admission to the BScN program is on merit basis, it requires a lot preparation, and if a person gets admitted, then it means that the person is very intelligent . . . . People also have an idea that BScNs get into leadership positions faster than diploma nurses, . . . perhaps within two years of their career.

As Hirah, Aamna, Atya, Anum, Daud, and Komal noted, nursing has a very positive image in the Ismaili community. I will discuss later specifically how they decided to enter nursing as a profession. However, an excerpt from Adil's interview indicates that people in the non-Ismaili community also have a positive perception of BScNs:

> Whenever I tell another person that I have a BScN, they know what a BScN is—has meaning [importance] in nursing. Then they show respect for me . . . . Most of the time I feel proud that whatever I have done, somebody is appreciating me, and that gives me enough courage plus confidence.

### *Rewards and Opportunities*

The informants identified various opportunities and rewards that they have had or may have been able to access because of their qualification as BScN nurses. Of the 16 informants, 9 commented on the opportunity for faster career growth, better chances for higher and continuing education, and job promotion. One informant commented on the monetary reward, that is, a higher salary than that of diploma nurses. However, most of the informants were not happy with their financial situation at AKUH and cited it as one of the major reasons for the high turnover of BScN nurses, which I will discuss in another section of this chapter. The participants commented on the rewards and opportunities that they have or that other BScNs have, which is inspiring for them, and Kanwal affirmed:

> I feel proud that I am a BScN graduate and not just a diploma, and people in my unit, they also say that a person who has done their generic BScN or who is a graduate in nursing has a quick career ladder, so they can be Team Leaders [TLs] quicker than general diploma nurses. If they are very competent, they can go ahead and progress, . . . and this has happened in my unit. One of the BScN graduates, she—after one year of experience in this unit—is now a TL, . . . and this has happened for the first time that such a junior nurse has become a TL, because in our unit we have a lot of senior people, a lot of people who are there, very competent, very knowledgeable . . . . This was the first time that a BScN was given a chance so early.

Nevertheless, the interpretation of opportunities varied based on when the opportunity was offered and in what kind of work environment. For example, some informants had the opportunity to work as team leaders within the first three months of their work experience at AKUH. In Hirah's view, this was a reward in recognition of her professional capabilities. To the contrary, Aamna did not appreciate this opportunity, but found it overwhelming as a novice nurse. Although Diya was able to analyze the pros and cons of this opportunity, she acknowledged that it enhanced her self-confidence despite the fact that it was an overwhelming responsibility for a novice nurse like herself. Diya revealed that it was the fifth week of her career as a staff nurse when she was forced to become a team leader:

> I said, . . . "I cannot take all those challenges as a team leader." A team leader means that you have to take care of the whole unit, address every concern; you should know every concern of the patients; there are many things [to do] . . . . But then I gave it a second thought and did it . . . . More responsibility and less time was a problem, but I got the chance to do everything independently.

A number of informants including Anum, Hirah, and Komal indicated that one of the advantages of the four-year BScN program is that it is a kind of fast track in nursing that students appreciate in an age-conscious society such as Pakistan, as parents usually wish to see their daughters married before they are 25 years old. Anum said that "being a graduate, people [nursing colleagues] usually say to you, 'Oh, you have done your BScN in four years.' . . . You can go for higher studies quickly, so it's a good opportunity."

Two key informants, Huma and Bahaar, and another informant, Inarah, had the opportunity to be trained first to be able to teach others. Huma noted:

> Sometimes management thinks, I as a BScN graduate, have good knowledge, presentation skills, and problem-solving skills, and I am proactive in my work . . . . At times they think that BScNs are fast learners, so I get the chance to learn new things. They teach me first to teach others . . . . For example, the software learning packages in our unit, I was taught first.

Like Huma, Bahaar also had an opportunity to attend a two-week specialization course relevant to her area of work that was offered by an expert from North America. Because space in the course was limited, management decided to enroll Bahaar in it. Bahaar sounded proud and appreciative of this opportunity, as reflected in the following excerpt:

> I was bestowed by my management during my first six months on the unit . . . . Only one nomination could be sent, . . . and my management people selected my name as the first one who could go [name of the course] for the course and could learn more, and then to come back and to teach the other staff as well. So I was feeling very fortunate.

Inarah was chosen to be part of a team at AKUH that was sent to another country to learn about bone marrow transplant. She explained:

> We developed a teaching module, and I started teaching. Staff from the whole hospital, including the medicine and paediatric departments, used to have problems with the Hickman catheter, and then I and my team, we taught them how to do dressings and everything, . . . and I trained [counts] almost seven nurses here.

### *Challenges*

On the negative side, the informants discussed the challenges of "being a BScN," including high expectations of self and others as well as resistance and resentment in their work environment. In sharing their stories of the work environment, they also speculated on the cause and effects of the existing situation and expressed their feelings and reactions to them.

#### ***Expectations***

About two thirds of the informants talked about high expectations. Most of the informants shared their experience of others' high expectations for them. However, some informants particularly those in the first cohort, indicated that their self-expectations were also high and rather unrealistic; hence, they experienced a greater reality shock than did the successive cohorts of BScNs. For example, one of the informants disclosed:

> When I was studying in the degree program, . . . we thought that we are going to be nurses, but a bit different, a little bit; our level would be a little bit higher. So from our group, a few of the people have changed professions after graduating with a BScN degree as well . . . . They were saying, "We have a degree, so we should go; we should be treated differently [in the work environment]" and "These things are not for us." But when the reality shock hit us, . . . at times we said, "No, these are the things which we have to do!" So it was difficult for us.

Likewise, another informant said:

> I was expecting that I am so thoroughly prepared with the theory portion, that I will be able to manage my work or perform skills at an optimum level. But it was not a realistic approach because for many things that we were dealing with, it was our first time. Maybe we had read about it, but in practice we were just being exposed to it, so it was very difficult to integrate theory into practice . . . . Maybe we were expecting more from ourselves, that when we will be going to the units, we will be performing at our utmost level. But when we went there, we were just at the novice level.

Aamna thought that the expectations of her in her work area were high, and she reflected on her preparation in the BScN program. She then went on to describe some of her experiences to support her assertion:

> I found that the expectations were a bit high at the initial level, or of the initial graduates. Most of the things which were taught to us were similar to the diploma program in the initial years . . . . We were taught together, worked together, so most of us were a similar calibre to the diploma nurses ; a bit more than that, but not so much . . . . But the expectations of the unit, of the management, was a bit high.
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> Usually when there is a new nurse [on the unit], that person is first supposed to work the morning shift with the head nurse or with the CNT [clinical nurse teacher] so they can get enough exposure to the environment. But because of being a BScN graduate, I was given night shifts after only two weeks on the unit, and soon after, . . . I started shift duties. Within a week I was expected to do double duties—that is, evening plus night—which was not acceptable because I certainly needed time to adjust to the environment. No doubt, even if you have worked on the same unit as a student, you still need time to adjust to the environment as a staff nurse. There is a difference. Within a month or one and a half months I was asked to become a team leader. I was assigned team leader with the responsibility for doing the medications for the whole unit, which was more than 40 to 45 patients.

Aisha added, "There were a lot of expectations when we went to the floor . . . . The CNTs were checking on our work. They expected that there would be a vast difference between a diploma and a BScN graduate for writing nursing notes." Kiren expressed similar views to Aamna's:

> They expect you to be skilful in all respects. The expectation is totally different, totally different from a BScN graduate compared with a diploma. If you are a BScN graduate, you hear, "You are a BScN; you should know this, and you should be able to apply this or that." They also expect you to be good and competent in our psychomotor skills, but it is not true in real-life situations because we and the diploma holders have spent a similar amount of time learning psychomotor skills. It is true that we have more courses than they do, such as research, but there is not much difference in [the time spent] learning psychomotor skills. How could you demand better practical skills on day one from a fresh graduate? In my unit on day one I was expected to have perfect psychomotor skills, but it was not the same with my diploma counterparts.

Anum, among others, also thought that the expectations of BScNs are high from the first day in the work environment. They are also told, "We expect you to know this because you are a BScN," or this message may be given nonverbally through body language:

> Sometimes they say it, but sometimes their expectations are nonverbal; they don't always say it, but either in their dialogues or indirectly, . . . such as when you are introduced on the unit, or saying, "You must have covered this in your BScN program."

### *Comparison With Post-RN BScNs*

Many of the informants complained that they were expected to work as experienced nurses instead of as novices. They identified competence in psychomotor skills as one of the major concerns of BScNs. A number of informants indicated that they were being compared with post-RN BScNs who had received their degrees after a few years of work experience. In their view, it was unfair to expect the same level of efficiency from novice nurses even if they had a degree. Atya recalled, "I needed some time to adjust myself and come up to the expected level [sighs deeply] . . . . But things went differently . . . . They didn't realize—then they fired back." Likewise, Aisha expressed:

> They didn't realize that these BScNs [four-year] are not post-RNs; they were comparing us with the post-RN BScN graduates . . . who had experience and we didn't. We had a good theory background, but we lacked the experience, for which we needed to pull ourselves . . . . So that part was not helpful . . . because they expected us to do things in a proper way, . . . because they were expecting that, being BScN graduates, we must know everything . . . or perform at an optimum level. This became a hindrance in our learning because we were trying to learn everything by ourselves; they never helped us.

Anum observed that BScNs are questioned by their colleagues and supervisors if they are unable to perform at a certain level or make mistakes:

> I feel that they were expecting a lot from a BScN nurse. They expected good knowledge and skills because "You are a BScN," the same as those nurses who do a BScN after having had some experience . . . . So the expectations from us are also quite high, and if you are able to fulfil the requirements, then the results are positive about you. But if you are not able to fulfil the requirements, then I have heard from certain persons, "They have done a BScN, but they do not have knowledge and they do not have skills." So I think that when you enter a unit being a BScN, they presume . . . you would have good knowledge and skills . . . . For example, if I am performing a particular procedure and I make a mistake, if

> anything goes wrong, then they will say, "You are a BScN graduate, and you must have knowledge regarding this. If you don't know this, then how have you completed your BScN?" . . . or "What have you learned in the BScN program?"

Similarly to Anum, Komal also thought that the expectations of BScN nurses are high because of the attitude of "No room for mistakes; you should know it!":

> If we ask for help . . . or if something goes wrong, then they say, "Oh, you are a BScN graduate, and you don't know how to do this?" So these are the comments which we frequently hear from our team leader or from the head nurse.

In addition to high expectations from self, supervisors, and colleagues, Anum pointed out an important societal pressure when people question BScNs' working as staff nurses: "They will say, . . . 'You have BScN degree, and you are still working at the bedside? Don't you have a post, or haven't you progressed in your clinical setting? So what is the use of your education?'" Similarly, Arzu, another informant with few years of experience as a BScN graduate noted:

> If you have one to two years of experience, you should be in a position of leadership because you are a BScN graduate! There are so many people who feel awkward when they see BScN graduates at the bedside: "They are BScN graduates, and why are they not in some position?" Many times when I talk to my junior colleagues who are graduates of the BScN program, they also have the same feelings, and if you collect data, there are many graduates from 2003 and 2004 who are working at different places [other than AKUH] in a position; they don't feel appropriate to work at the bedside.

Likewise, the graduates' families also have high expectations of them, as is reflected in the following comments from Inarah:

> I felt that I wanted to do so much, I wanted to do so much for this organization . . . . My dad always used to say, "I want to see you as a director, at the post of director of nurses or something, because you have that potential; you can do it." And I also thought, Yes, I can be one of the leaders for this organization.

It is important to mention here that many informants acknowledged that comparing BScNs with post-RN BScNs was not one sided. Bilal reported:

> Initially, there were high expectations for us, taking into consideration what our program had to work with. Remember, we always compared ourselves to the post-RN BScN, we always have this thing in our mind, and that is okay since that was a BScN program, and we were in a BScN program. They [post-RN BScNs] are

> graduates and automatically assume management positions as head nurses or CNT [clinical nurse teacher] faculty in the School of Nursing and so on. So in our initial years—you can say first and second year in our nursing program—we also had this sort of expectations of ourselves, . . . sort of automatically. So we basically assumed that we would have the same roles, same responsibilities, we would have the same opportunities.

When I asked why BScNs were seeing themselves differently from diploma nurses, Atya responded:

> Basically from the selection criteria, because we are taking a BScN after intermediate; [Grade 12][1] that is a requirement . . . . Plus in the selection criteria people who are selected are those who are the cream. In our class most of the people had intermediate with medical or engineering background and had good grades, A or A+ grades, these were their intermediate grades. They could have got admission into the medical colleges or universities, but they didn't go there and joined here. We had heard that this is the first program in Pakistan, so we had a different perception in our mind of this program, different than a diploma in nursing. . . .
>
> We have been treated very special, as a special group in the School of Nursing, so we're very privileged and very lucky to have a few advantages, but we were also the guinea pigs [laughs] as well . . . . In interpersonal relationships they [teachers] were very open . . . . In the classes which we were taking with the diploma [students], the difference was very evident between them and us. BScN students had a good educational background, so they were good in English and sciences as most of them had a science background. So BScNs dominated diploma students in the classes . . . . In year three we began to take [combined] classes with the post-RNs, so when we were taking classes with the post-RNs, some feelings automatically developed: "We are little bit . . . different than diploma [students]. Because we are taking classes with the post-RNs who are more mature, who are more experienced, it means they are special, so we are special." [laughs] . . . So nobody was saying it to us, but that was the inner feeling that we developed.

### *Resistance and Resentment*

Many informants recognized their colleagues' and supervisors' sense of resistance and resentment towards them in the work environment. Some felt their supervisors were biased towards them and treated them differently than they did the diploma-prepared nurses. The informants found this demotivating and discouraging. Some also commented on the difficulties that they faced when they tried to practice what they had learned in their professional education. Although some graduates talked about themselves as individuals, most referred to themselves as *we* because many had had similar experiences that they discussed with their classmates. Similarly, in referring to their supervisors, the informants used *they* in a plural form instead of *she* or *he*. Atya reported:

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[1] Nursing students may be enrolled in the diploma program after Grade 10 of their schooling.

> [illegible] we requested a change in our shift or wanted to take an assignment which we liked, or whenever we complained about anything that we didn't like, we found that their [supervisors'] attitudes or behaviour was a little bit different with us than the diploma graduates.

Like Atya, Kiren felt that "I was kind of singled out for things regardless of what the diploma holders were doing. Plus, diploma graduates support diploma graduates. BScN graduates are criticized and commented on one way or another." When I asked Kiren to elaborate on her comment that "diploma graduates support diploma graduates," she replied that both her head nurse and the CNT are diploma prepared, and they usually favour diploma over BScN nurses. Commenting on her experience as a BScN graduate, Inarah, one of the other informants expressed:

> I felt that I wanted to do so much with all my potential, but I thought that whatever I wanted to do, those things were not accepted; and if they were accepted, they were not acknowledged . . . I wanted to do something good for the department, . . . to build good policies, to make good nutrition plans for the patients . . . . But it was either not appreciated or not seen as something that I really should to do because I was being stopped . . . . I was told, "We want you to totally care about patients: Come to your shift, do your work, and then go home."

Likewise, Hirah's supervisors had criticized and discouraged her from working hard. She gave a specific example:

> If I did the patient assessment in detail, I would write in detail, but they wouldn't appreciate that or say, "You have done a good job." Rather, they would find mistakes in my work and say, "Why have you written this? Why have you done this?" I know there is a way to teach if you want to evaluate or guide others. In that case you would say, "These are the positive things, and these are the areas for improvement," but whenever I filled in the patient assessment form, she [head nurse] would call me and say, "Why have you written this? Why have you written that?" So once I remember saying to her, "I won't fill the patient assessment form any more," because it was demotivating for me. I thought, Why am I doing this if there is no use for it? I shouldn't be writing this if at the end I will be scolded for it! In other words, I was not encouraged for what I was doing.

I asked Hirah, "Was that happening only with you on the unit?" and she responded:

> No, not only with me, . . . [with another BScN], . . . my class fellow and colleague, but she was very assertive . . . . I was scared of the HN [head nurse]; I used to feel scared. I didn't have the confidence to say, "This is your mistake, and you have done this." But my colleague, . . . she was bold; she could say things to their face. But I think there is an aspect of respect—you should be giving respect to your supervisor; there is a way of talking to them. But my colleague was not like that; she would tell them to their face. However, I couldn't do that.

Although Hirah saw her colleague's assertiveness as an advantage, Daud thought that his assertiveness did not work for him, but instead created problems for him because he was viewed and labelled aggressive rather than assertive. Daud reflected on his experiences:

> We were excited that we are BScN graduates and that we would make some difference in the work environment, but once we started working regularly in the clinical setting, we found that, as such, there was no difference between other nurses and the BScN graduates. We tried to implement what we had learned in our school, but there were so many things that they did not allow us to do. There were some challenges, in fact. For example, we learned assertiveness and all these things, and we used to talk to our teachers like friends. Once we went into the clinical setting, we practiced the same thing. For example, with surgeons or with consultants or anyone else, if somebody was doing something wrong, we would say, "This is wrong." There were so many problems that we were facing. Initially, we used to get involved in the situation, but then we just got used to what we tried to change. Finally, we had to change ourselves because we couldn't change others.

Daud elaborated on his difficulties with being assertive:

> That was during my initial two months in the unit, I guess. I had a patient with some complications after surgery; he was paralyzed . . . . Suddenly the patient's blood pressure and temperature started going up. The patient's family was around, so they were asking, "What is going on with the patient? Why are you not calling the doctor?" . . . So I paged the residents, and nobody was responding. I informed my TL [team leader]; she said, "Just inform the surgeon." I didn't know that the surgeon was in the OR at that time. I informed the anaesthesia doctor.[2] He said, "I can't do anything; inform the surgeon. If the resident is not responding, inform the surgeon." So I paged the surgeon. He was in the OR, and he started shouting. He said, "Who is this? Why are you informing me?" I told him, "There is nobody whom I can ask, so that's why I paged you." He said, "I am not a resident; I am a surgeon! You should ask for a resident or somebody like that." So I said, "No sir, I think the patient is under your care, and I think I am doing all this for the patient.

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[2] Anesthesia residents are also responsible for the respiratory/ventilation management of patients in critical care. Hence, for any issue other than patient ventilation, residents of the primary team are contacted.

> And if nobody is responding, you are responsible. And if, God forbid, something goes wrong, you will directly ask me because I am assigned to this patient. So I have to inform you." He said, "Who are you, and where have you studied?" I said I had studied at AKU. So he said, "If this is the case, then I will not allow you to touch my patients." So I said, "Okay, fine. If you feel I am not competent enough to take care of your patients, I'll not take care of your patients. I don't have any problem." And I said, "I am here as an employee, and I have to take care of any patient, not just your patients." So then he just hung up the phone, and he came to . . . [the unit] and started shouting, "Who was the person?" and this and that . . . . I didn't change my point of view. I said, "I was doing all this for the patient. The patient's condition was not good, and there was nobody to help. I did the right things; I went through proper channels. I informed my TL, I tried to access your residents, and I informed the anaesthesia team, but everybody refused and said we can't do anything. So finally I had to page you." . . . But he was trying to [bully] me; he said, "I will talk to the director of nursing, . . . and I will kick you out of here!" So I said, "Okay, go ahead, whatever you want to do." I said, "I feel I haven't done anything wrong for the patient. If you want to do anything, you can go ahead, and I am not afraid for my job and all . . . . And if you feel that I am not competent enough to take care of your patients, okay, I will talk to my manager. And from now on, I will not touch your patients because I am not getting my salary from you, and I am not here for your patients because there are three other surgeons too." So he was so annoyed, but later he came to me and said, "I am sorry; I was wrong."

Daud also recalled:

> I went to the general unit to transfer my patient. There were three RNs, and I asked them to receive the patient from me. Nobody responded, and they were just ignoring me and saying, "We are busy, we are busy." In fact, I had informed them an hour before that I would be coming with the patient so that they could be ready to receive the patient. So I settled the patient in his room [semiprivate room in a unit], I put him on oxygen and all these things, but nobody was there. So I asked the assigned RN, "Can you please take over from me because I have to go and receive another patient from the OR?" She said, "I am busy" and this and that. And I approached her TL: "Please, somebody should receive this patient because I have to go back. The patient is settled and I have written my notes, and I have to go back." . . . Maybe I was aggressive, but I was trying to make them realize that they were making me late . . . . Then they approached my supervisor. The supervisor came over and listened to our views. There were three people and I was alone, so they started . . . making comments: "You were aggressive." In fact, I was not aggressive. Maybe there is a minor difference between aggressiveness and assertiveness, so this was a problem for me [chuckle].

It is important to mention that after some struggle, Inarah and Daud left AKUH and joined another institution in Pakistan with a better salary and work conditions.

Nevertheless, from their conversation it was clear that they were very loyal to AKU and not reluctant to return if the work environment improved.

Arzu thought that management is biased about BScNs:

> It has also been observed that if in a unit you have vacancy and you have a post-RN BScN and a BScN with the same experience and same competencies, it is more likely that the post-RN BScN will get the post, and if you ask the management, they will definitely give you reasons but generally it has been observed that mostly positions are being given to the post-RN BScN nurses. They [management] have the concept that post-RN BScNs are more capable as compare to BScNs. I do agree that they have more practical experience but it's not true all the times.

***Sarcasm and scornfulness.*** Almost every informant recalled a denigrating or sarcastic comment. Some were general in nature, whereas others were directed at a particular individual. Anum observed that non-BScN nurses would often comment, "Oh, BScN, *karr liya tu apnay aap ko kya samajhtay hein*." ("Oh, they have done a BScN, so they think big of themselves). Likewise, Huma reported that on her unit,

> sometimes they [colleagues] degrade me by saying, "Oh, you are a BScN, and you don't know this?" Even though it is very normal sometimes that a person with PhD may not know everything, I am expected to know everything, so it is frustrating at times. It is very challenging to work as a BScN nurse because everyone, all health care workers including consultants and unit clerks, say sarcastically, "They did a BScN, so they think that they can bring changes, but they don't have the skills. They can only talk about issues which cannot be changed."

I also noticed this kind of attitude towards BScN nurses among the nursing management group at AKUH during a meeting at which I sought access to the field site. Kanwal told me that in an inservice session one of her supervisors had referred to her as *hoshyar*, which means clever:

> The supervisor was talking to another nurse about ### [the physiology of the human system], . . . and then she just touched my back and said, "Okay, why don't we ask her? She is very clever." But that clever was not used in a very positive sense; it seemed to be more sarcastic. So that is something I did not like [smiles]; I did not like it.

Kanwal also shared another example to illustrate how a post-RN BScN on her unit had taunted her:

> Right after convocation when we were . . . in the transition phase, in the learning phase, getting acquainted with everything, we would find a lot of things which were new to us. So once during my first two months it happened that I was standing in the distribution centre, and I was asking the man for eye packs. And he said, "This is the cupboard; you have to unlock it and get the things from there," but I couldn't find it because things were happening very haphazardly and hastily, and I couldn't find it. And one of the nurses who had done her post-RN BScN with us—she also attended classes with us because we attended a few classes together—commented, "*Aata jata kuch nahee hai* [they don't know anything], and they get all the awards." I was literally shocked, hurt, and I said, "I think we shouldn't talk like this." So I didn't like what she said because that was totally sort of taunting in a very bad manner, and it showed that she had some sort of grudge or maybe she had negative feelings about us because we were doing well in our studies, and now that we are in the work area, we are less senior to her because she has worked more in that area; she is three years senior to us. So she was sort of putting us down . . . . She is referred to as a BScN, and I am also referred to as a BScN [smiles], but she has . . . three years of experience, and our title is the same.

Kiren alluded to one of the very common criticisms of BScN nurses at AKUH:

> One of the things is that BScN graduates are accused, "They are here for a year only." This is true to a certain extent, because many of them have gone to the UK and other places; however, diploma graduates also leave. If one BScN goes, five diplomas are also leaving here because there are more of them. When I joined here, I was one from my cohort, but there were four or five diploma from AKU-SON.

Kiren reflection on the above issue is supported by the resignation data from critical care areas, which I had obtained from the concerned manager. According to that data, 58 nurses resigned from Critical Care Area in 2005. Of the 58 nurses, one was a post- RN BScN, eight (14%) were four-year BScNs, and 49 (84%) were diploma nurses. And of the 49 diploma prepared nurses, 30 were AKU-SON and 19 were non-AKU-SON nursing graduates.

***Speculation about resistance and resentment.*** As the informants talked about the resistance and resentment towards them in the work environment, they also speculated on the various reasons for this attitude. Some informants from the initial cohorts of the BScN program linked the resistance and resentment to the change process because, in their view, the status quo of the diploma nurses in the work environment was threatened. They believed that most of the diploma-prepared nurses found it difficult to accept BScN nurses because they received their degree in four years instead of seven, as is the case for post-RN BScNs, who spend three years to complete their diploma and then must have at least two years of work experience to be admitted to a two-year degree program. Aisha observed, "People were trying to accept our existence, as this was a transition period in the process of change." In her view, the basis of the resistance, to a certain extent, was the gap in information between AKU-SON and nursing services:

> Because they didn't know what kind of program we were coming from, there was a gap between the School of Nursing who was running the program and the people who were recruiting us. Though people at the top level might have some awareness, . . . people we were working with, they had no idea what kind of program we were coming from.

Aamna also expressed a similar view. However, of the 18 informants, 9 thought that their supervisors, such as head nurses or team leaders, had been diploma prepared; and in their view, this was the source of tension and competition among BScN and non-BScN nurses in the work environment, as is reflected in the following accounts:

> One of my supervisors was a diploma graduate, and there were a few other senior nurses who were diploma graduates. They were always scared that we might take their positions, so their feeling of jealousy or feeling of repulsion was very evident; it was very evident. [reflects] . . . They always claimed that BScNs *aaye hain, kuch aata jata hai nahee, mugar* management position in *ko mil jaye gi* [These BScNs, they don't know anything, yet they would still get management positions] and things like that. So there was a kind of repulsion or a kind of ignorant behaviour which we had observed on the clinical side. (Atya)

> She [head nurse] was very biased. She might have thought that perhaps I work hard for some reward, but one cannot think of working as a CNT [clinical nurse teacher] in the first six months . . . . Though my relationship with the staff was excellent, there is an aspect of jealously and competition between diploma and BScN nurses with regard to career promotion. (Hirah)

> Besides our colleagues, who have high expectations of us because "You are BScNs," our management kinds of avoids us. I feel that there is some sense of insecurity. I had those feelings because my team leader, CNT, and HN are all non-BScNs. I think they have this feeling, that we [BScNs] may not be competent in our skills now, but they can be learned in a few years, so what will happen then? We may be competing. (Kiren)

Diya reported her experiences in the work environment, particularly her relationship with her CNT and head nurse:

> I think it is like crushing us or pressuring us . . . . I think that because there are no BScN nurses on my unit, perhaps they [supervisors] . . . fear *kay kaheen hum say aagay na nikal jaey* [that I may compete and leave them behind]. So these people do not send me for any continuing education . . . . For example, recently, they sent my other colleague for ### [course name], but they did not allow me to go.

It is interesting that the perceived sense of insecurity among non BScN nurses depicted in the above accounts was not one sided, as Atya disclosed:

> There were a few nurses who were very good in that [psychomotor skills], who were helping us, but again some senior people had a very strong negative attitude [sighs deeply] towards us to the extent that it hindered our learning. I was scared to ask anything because I was afraid that my performance appraisal would be in jeopardy if I asked this or that . . . . They might think, "She even doesn't know this," so I tried to learn by myself.

Inarah further elaborated on the tension between the four-year BScNs and others who had a diploma or a post-RN BScN:

> In the unit where I was working for more than three years, 95% of the supervisors used to say, "Generic BScNs are a threat to us." . . . I have seen them verbalizing it [the participant became very loud and emotional at this point] . . . . They think we are motivated, we are young, we are energetic, we know the system ins and outs because we catch up things very fast [able to observe what is wrong and make them accountable], so that's why we can put them down. But they don't understand that when you work in a system, you cannot work in opposition; you always work together. So that was always there. I wanted to speak to them, say, "See, it is not like that. We are all a team, because when you talk about a multidisciplinary approach, then you don't talk about separate groupings; you talk as a group, as a whole." But what happened with me, whenever I wanted to develop this feeling among my colleagues or with the supervisors, I always had a feeling that they thought I was bypassing them, which really hurt me a lot, and it was one of the reasons that I wanted to leave this organization. I just wanted to leave, because, okay, whatever I want to do, I feel that I am unable to do it here. Let me find a space where I can feel that the sky is open for me, and let me go; let me work in a system that does not have all of this.

To put things into perspective, some supervisors also acknowledged specific characteristics of BScN graduates. Positively, they viewed them as energetic, enthusiastic, and fast moving; but negatively, they characterized them as idealistic, demanding, and aggressive. Supervisors' views of BScN nurses are detailed in the next chapter.

***Fitting in.*** It was apparent from the informants' narratives that they use different strategies to fit in, fight back, or finally leave the institution. For example, some of the graduates from the recent cohorts were working to put an end to the negative impressions and perceptions of their competence, as reflected in the following excerpt from Kiren:

> There were a few BScN graduates on my unit before me who were labelled as being not good; people had an impression that "they don't know much." When I joined the unit I worked hard to wash out that impression. I wanted that BScN graduates not be underestimated for their skills, and I was successful to the extent that some of my colleagues commented, "We thought that you are a diploma nurse, not a BScN . . . . Oh, so you are a BScN." So when the graduates of 2005 came on board, I intimated to them that they should expect such comments—"She is BScN, but don't know this or that"—and not to take them seriously, but work on your skills [psychomotor], which is possible to learn in a short period. Then we all, the BScN graduates, worked on to fade that negative impression and to remove that label from the BScN graduates.

Like Kiren, Anum was also determined to accept the challenge and prove herself:

> I was feeling in my mind that if they [management and colleagues] have high expectations for us, then we have to prove it. So always from day one, I was having it in my mind that I have to prove it because if they are expecting that four-year BScN have to have these things, so I have to have this.

Kanwal tried to avoid sarcasm by not telling her colleagues that she is a BScN nurse until they saw her at convocation:

> First, people used to just take us as new graduates, new nurses, and later on when they found out, they would say, "Okay, you have done a BScN. Okay, four-year BScN!" They were very impressed by knowing that, but they came to know that later. We were not showing them that we have done a BScN and we are different from them; we never showed that. So it was maybe after two months when we had our convocation, most of the people saw us at the convocation, and when they asked, "Have you got a degree or a diploma?" so we said we got a degree. So that was the time that our head nurse and CNT took photocopies of our degrees, and that also made a difference, that, okay you have a degree and they have a diploma.

Nevertheless, the approach of some graduates was not as strategic as those described in the above narratives, and they openly expressed their feelings and showed their resentment when events conflicted with their expectations. For example, Diya reported a situation in which her senior colleague did not appear for her shift and the nurses on the evening shift could not work a double shift because of family commitments. Diya then assumed the responsibility of a team leader on that night shift despite the fact that she was very new in her role as a staff nurse. However, contrary to her expectations, her head nurse did not appreciate her accepting this challenge because, from the head nurse's perspective, someone from the evening shift would have remained if Diya had not been so willing to accept the responsibility. The following is Diya's response to her head nurse:

> I was waiting till seven o'clock, thinking that when it's seven o'clock, you will come and appreciate me, that "good, very good. Okay, you had no mistake." I was hoping to hear those words, . . . .because I did well, without any mistake and any blunder. But you are saying to me that I should have gone home. "Okay, next time I will do it [go home]." Then she looked at me and said, "What kind of answer is this?"

Diya's response to her head nurse is similar to Hirah's reaction (described earlier) when her detailed assessment of a patient was not appreciated and she said, "Okay, next time I will not fill the assessment form." An excerpt from Kiren explains why some graduates respond with similar sarcasm:

> I also learned how things are done as well as how to respond to people. I started to respond to their comments and deal with individuals considering their nature. Initially, I kept listening to everyone and not responding. Whatever they said, I heard that. But not now; I do respond. People can make mistake, but it doesn't mean you pressurize them. If you come under pressure, they will put more pressure on you.

Yet some graduates, such as Aisha and Daud, tried to ignore the situation for the time being and searched for other opportunities. Daud said, "There were certain things which were problematic initially, but later on we had to just ignore these things because we couldn't change it." However, apart from how individual graduates might respond or act in their work environment, there was a growing realization and understanding of the differences between BScN and post-RN BScN graduates. For example, Aamna stated:

> I can understand that doing a BScN makes a difference compared to diploma, but experience makes a greater difference. So I think that a person or whoever the graduate may be, they need to have good experience in order to acquire a leadership position and be the role model for others.

Bilal reported that as students in years 3 and 4 of the BScN program, they would have discussions about the role of BScN graduates in the work environment and question the differences between themselves and post-RN BScNs. He indicated that they developed an understanding of these differences, but understood them better when they began to function as staff nurses. He believed that he was now in a better position to respond to his juniors when they asked the same questions that he had when he was a student:

> We all have to sit down; I mean, sit down and explain to them the reasons, that, "Look, we went through the same phase; I went through the same stages," that being two years down the road [having two years of work experience], I haven't understood all of that. "You need to have some sort of clinical background for you to teach somebody else. If you don't have clinical experience and the student asks you a question, what are you going to respond to?" Even at this point in time, even two years and two and a half years down the road, I still say that I do not have the complete information that would qualify me as a good faculty member.

It is important to point out that all the aforementioned challenges that the informants described were related to the work environment at AKUH. As indicated earlier, some of the key informants are now working in the School of Nursing or have joined other health care institutions (hospitals or nursing schools). When I asked these informants how they viewed their current place of work, they reported contrasts from their experience at AKUH. For example, one informant said:

> My experience in the school was very nice; in fact, I should say [smiles] very nice in the school. I didn't find any kind of discriminatory behaviour . . . . The school is always encouraging. What I feel, that school has an open-heart and open-hand policy, and the school always encourages people to come and join them . . . . So I didn't find any kind of negative feeling in the school . . . . Whenever I need help, any kind of help, I can ask for help from anybody. Everybody is very open to giving advice and all. So I have a very good—in fact, positive—feeling about the school. I am happy to be at the school because I don't find anything negative in the school management or school environment. It is very promoting and motivating, which helps us to grow ourselves and as well as helps others to grow.

Likewise, another informant responded:

> In the school I had a very supportive environment. I got excellent, excellent mentorship when I was here. They showed me how to guide students, how to advise, or how to guide them for proper resources, how to work within a team, how to formulate [develop] a course, and all those things. I worked within the group, and the group supported me a lot.

Daud compared the working conditions and other incentives:

> When I resigned from AKUH, they [current employer] sent me an offer for a teaching position. I wanted to see their campus before joining . . . . He [a senior officer] took me to visit the whole campus . . . . There was no interview. He said, "you have a degree from AKU; we don't need to ask you anything. Let's discuss the package, what package you would like." As a staff nurse at AKUH my salary was about 11,500, but after deductions I used to get about 9,000 or sometimes 10,000. But now I am getting 20,000, with free accommodation and other facilities, including telephone and cooking. The duty time is different here. There I had to do shift duties; sometimes I even worked for twenty-four hours because of staffing situations. But over there I have to go in the morning at eight-thirty, and I come back at four o'clock, and I get more time to study and improve my knowledge. The skills part is also improved because I take students to clinical settings.

Another informant, Areeb had similar experiences as Daud: "There is a great value of a AKU BScN degree wherever you go, everyone respects you, even they don't bother to take your interview. I always feel proud to be an AKU grad."

Among others, Hamid and Inarah had also joined a non-AKU organization in Karachi. They both received a better package than at AKUH. About the work environment, Hamid said:

> My experience at the Aga Khan Hospital was not good, but at the institution in which I am working now, I am feeling very comfortable. The working conditions are not stressful. We set up a time for our prayers and also for lunch and dinner. So I have no feeling of hesitation if I have to go for my prayers. I can tell my colleagues to look after my patients, and then they can do the same, so it means that there is cooperation among us. So these things are very helpful.

Inarah seemed to have mixed feelings in the new place that she had joined two months ago. She reported that she has the autonomy to do many things, but she complained about a lack of systems and patient-care resources, which was in contrast to her experience at AKUH. In addition, although she is more qualified in terms of education, she is much younger than her staff, and most of them have worked at that institution for more than a decade. She explained:

> It's a kind of experience that I never expected, because there is no system you can see; you have to develop a system. But the people are very good; they are very motivated, although I see some resistance because there are many staff who have working there for twelve or fifteen years, and in front of them I look like a kid.

> And when they feel a kid is managing a department, they may feel frustrated. But on the whole, I feel good because they have started accepting me . . . . Secondly, whatever changes that I want to make, I am able to do that, but there is no smooth way; you have to find your ways.

Elaborating on patient-care resources, Inarah gave an example of hygiene care. She expected her staff to provide oral hygiene to their patients and then realized that they do not have the necessary supplies. Like Inarah, Hamid also lamented that a lack of patient-care resources was affecting his performance as a nurse.

### *Relationships*

In describing their relationship with colleagues and supervisors, only a few of the informants seemed to have a good relationship. Apart from Bahaar, generally, they were not happy with their relationships with their supervisors, as indicated in the narratives above (Atya, Aisha, Aamna, Diya, Hirah, Kiren, Komal, and Inarah). Although some received partial support from their colleagues, others did not. For example, Diya said:

> I am pretty okay with my colleagues. They are very motivating for me; they have always been very supportive to me. They empathize with me and tell me that "this is happening with you because these management people really want you to leave this unit because no one else could survive here [previously]." . . . But when ten people are on my side, and if two of them are not, still, it gives me satisfaction that, okay, if I am doing something for my people or for patient, this is okay . . . . I am satisfied with the colleagues actually, but not with the management.

Adil had a unique positive experience, unlike the rest of the informants:

> I have an interactive relationship with all my colleagues. When we are on the floor we work as a team, regardless of who is the team leader. Whatever the team leader delegates, whatever works, any task to be done, we do it. We distribute the tasks in our team: "You do this, and I will do this," and then if somebody needs help, we do help each other, so that's a good thing . . . . There is no negative feeling because on the unit we are all the same; whether someone is technician or a nurse, all are staff, . . . so it's positive.

To the contrary, Hamid had not had any positive experiences, whether with management or colleagues. He described various situations that showed he had perceived a complete lack of support from his colleagues. For example, usually he was assigned to the area of male blocks or the area reserved for male patients, but a female nursing assistant teamed with him. However, this assistance was of no benefit because he would have to do most of the work, including the patient's personal-care (hygiene care) to respect gender sensitivity. In another example, during his night shifts in the month of Ramadan, he was required to have his *sehri* (breakfast) before dawn, but it was difficult for him to do so:

> When I wanted to go for *sehri*, my team leader asked me whether "the patient care is important or your *sehri*?" So that point put me into a dilemma that whether I should go or not. And from that night, I stopped going for *sehri*, and then I would suffer for the whole day . . . . So I was having no cooperation, or there was no cooperation, team efforts, or teamwork. I don't know what was the basic reason. It may be that I was weak in making the rapport, or maybe something else.

It is important to clarify that the majority of the nursing staff at AKUH are Ismaili, and that their fasting requirements are not the same as for Sunnis. Because Hamid is a Sunni, it was compulsory for him to fast in the month of Ramadan.

Atya, Kiren, Kanwal, and Komal had received more support from critical care technicians (CTTs) than from their nurse colleagues. It is worth noting that one of the key areas in which the BScN nurses initially felt inadequate was psychomotor skills. On the other hand, CCTs have good psychomotor skills; furthermore, in general, they are accountable to nurses, whether they are diploma or BScN prepared. Thus it is not difficult to understand why CCTs are more helpful to BScN than to diploma nurses, as indicated below:

> Most of the time I was assigned with senior CCTs who have ten to fifteen years of experience working in the unit. I used to work in the . . . [place of work] with a CCT, so they taught me how to set patient-care priorities, take care of this and that, so they helped me. (Kiren)

> What we usually find in a unit is that all the nurses have one year experience or at most two years of experience—you won't find the five years or six years experienced nurses—but all the technicians, . . . the CCTs, more are seniors and more experienced, and the nurses are less senior . . . . If an RN has one year experience and if a CCT has ten year experience, then usually there is a difference between the CCT and an RN. For example, if I have to do a cannulation on the patient or have to put an NG [nasogastric tube], I may not be able to do that in one attempt, but a ten-year experienced CCT will easily do it in a first attempt. (Komal)

Kanwal had not only learned various psychomotor skills from CCTs, but had also acquired some technical knowledge, such as ECG interpretation, and benefited from their knowledge of unit policies: "So they are the ones who guide us all the time. This is very helpful." When I asked the graduates whether there were any implications for their initial learning from CCTs, Kiren and Komal revealed some interesting situations that are not difficult to imagine within the sociocultural norms of Pakistani society. According to Kiren:

> You have to care for their status as they are more experienced than you; you have to ask for their input. If you want things one way and they want it another way, you get to consider that. Rather, I would say I do consider that . . . at times it is a compromised situation . . . . For example, yesterday I was the TL for my shift. One of the very senior CCTs was in my shift. I had assigned him for . . . [details of the assignment]. He came to me and questioned why he was assigned for . . . [these duties]. I tried to explain the situation and assured him of my help . . . . Then later in the shift I requested him to help . . . . He helped once reluctantly, but refused the second time, so this time I ignored that and didn't insist, but rather tried to manage the situation by myself. So it is not easy to deal with a person who has that many years of experience, while I am very new, considering his experience. So yes, at times you have to consider their experience, and it may lead to a compromised situation . . . . But it is natural; you are somewhat reluctant to command them because you have learned things from them.

Likewise, Komal reflected on the implications of the relationship with a specific example:

> This is a usual experience for newly appointed team leaders . . . . The CCTs would say that she has learned from us, we have taught her, we have always helped her, and now she is a team leader and she is commanding . . . . The team leader has to consider whether I should say something to him or not, and if I say something to him, will he mind that? And if he does something wrong, then what should I do? He is my senior, I have learned everything from him, and now if he has made a mistake, how should I approach him? . . . Once one of my patients went into asystole [cardiac arrest]. The patient was already intubated, and he was on full code [resuscitation]. This happened when a senior CCT was bagging him. So I said "Okay, I am giving a rush call," but he said, "It is not needed because the patient is already intubated. You only inform the resident of the primary team." So I paged the primary team. When the resident came, he started resuscitation and asked me if I have given a rush call. I said no. So he said, "Why you have not given the rush call?" But at that time I couldn't say that the CCT had stopped me from doing that, so I said that I was not aware that I need to give a rush call in this situation. So he said, "You are working in a . . . [name of the unit], your patient is intubated and on full code, and you don't know that you have to give the rush call?" So I said that I am sorry; I made a mistake . . . . Later an incident form was filled for me.

Komal also alluded to CCTs' general feelings about nurses:

> Usually you hear a comment from the senior CCTs that nurses are only for name, but they usually don't know how to work with the patient or how to tackle an emergency situation. They always need our help though they have the license [registered nurse], the degree, and CCTs don't have a degree.

These feelings corroborate my observations:

> The team leaders of the evening and night shift were sorting out a staffing issue for the night shift because they were short of three nurses. Some of the evening staff were wondering who is going to relieve them; they came to the counter and inquired from the team leaders. They also expressed their concern of missing their regular transport if they couldn't be relieved by a specific time, while one of the senior CCTs came to inquire as who is going to help him with a blood transfusion for his patient. The blood pack had already arrived on the unit. With some frustration on his face, he made an interesting comment. He said, "Give us some more courses and turn us into RNs as anyhow we are doing many things that we are not supposed to do." After a while I learned that this CCT was assigned for 3 blocks during the evening shift (about 15 patients) and he had been doing almost everything for these patients except medications. (PO, June 24, 2006)

Most of the participants had little to say about their relationships with members of the medical team, except for Huma, Daud (as noted earlier), Bahaar, and Kanwal. However, many shared their views when I inquired about their role as a nurse, which I will report later in this chapter. Bahhar noted:

> There were few teams of doctor who were quite supportive, and again few teams who were not feeling like talking to RNs, avoiding to talk with nurses or anybody of the nursing staff. So, initially, I was trying to understand them, just keeping in view that what is the mentality of the different doctors, . . . whom to express more queries, or whom to share the patient concerns, and who is the right person in the team to approach who would be helpful for the patient and for the nurses. All of that came with experience.

Kanwal identified that communication with the medical team is a problem: "They are not very open. Either they are very demanding, or they may completely ignore you [as nurses]." Kanwal added:

> Sometimes they do ask, "Are you a diploma or a BScN?" They don't know everything about nurses, but they sometimes ask about what you have done and "if you have done a BScN, so has your head nurse done it? Has your CNT done it? And how is it helpful?" So these are the questions they ask; otherwise they also have this perception that a nurse who has done a BScN should be more knowledgeable, should know more.

Kanwal reported that, in general, she has come across three categories of doctors: those who talk to you to verify information and seek your help, those who question you to confirm whether you know the information or not, and those who do not talk to nurses:

> At the intern level they verify things from the nurses because they think that a nurse is working there since some time, so she knows more than me. So at that level they ask questions to get help, to verify things. But at a higher level, or when a resident asks some questions, that is to check whether the nurse knows or not; that is, you get the feeling [that they are thinking], What is the purpose of this person? What is the purpose of this question that he asked? You would get to know that.
>
> There is another kind [laughs] who don't ask anything from the nurses because they think nurses are not reliable; their information would not be reliable. So there is a third kind as well. The third kind of doctors, . . . who don't ask, who don't ask nurses, and who would rather ask their own intern or the resident. Or if they have to ask a nurse, they would ask the TL: "Okay [speaks quickly], that person is more reliable." So they don't rely on nurses in general. Those kinds of doctors are more common on my unit.

Overall, two themes traversed the above categories and subcategories: differentiation and association, and comparison and competition. The graduates themselves and others differentiated them as a distinct group of nurses based on their professional qualifications. Likewise, the graduates themselves and others compared their performance with post-RN BScN and diploma-prepared nurses, which has led to competition among BScN and diploma nurses.

### *Summary*

Although, in general, the informants were overwhelmed by the challenges that they had faced in their work environment as graduates of the four-year BScN program, nearly half were able to identify positive aspects of being BScN prepared nurses. The competition between diploma and BScN nurses is apparently one of the key issues that begins with the high standards for admission to the BScN program and intensifies in the work environment.

## The Experience of Transition From Student to Staff Role

To discover how BScN graduates found their transition from student to staff nurse and what they found helpful and not helpful during that period, I asked all of the key informants as well as some of the secondary informants, Aneel, Arzu, Areeb, Fatmah, and Inrah in the graduate category: "How would you describe your experience of the first three to six months on the unit?" Of the 16 key informants, 4 (2 female and 2 male) had six to seven months' experience as staff nurses, and one had nearly completed her fifth month on the unit at the time of her interview. Whereas, the rest of the informants had one to four years of experience.

It is interesting to note that all of the participants were able to recall their experience of transition vividly, regardless of how long ago they had gone through their transition from nursing student to staff nurse. Many verbal and nonverbal clues in their conversations revealed the intensity of their emotions on this topic. For example, Aisha sighed before talking about her transition: "Oh, very difficult. Takes time to adjust; took a year for me." Bilal reported, "It was difficult, very difficult. The transition period from the school to the hospital side was a challenge and a tremendous task." However, Diya and Kiren had difficulty identifying what was helpful because they were overwhelmed with what was not helpful. Kiren said, "Let me first tell you what was not helpful"; and Diya responded, "The helpful was . . . —must be something—let me think [reflecting with a smile]. I am pretty preoccupied with [what was not helpful]." Unlike all of the other graduates, after graduation Fatmah began to work in a community setting instead of a hospital. She reported no difficulty in adjusting to her new role or work environment because the nature of her work was similar to what she had been doing in her student role; that is, reading, preparing presentations, conducting sessions on health education and promotion, and providing care for postnatal women and children in the community.

The informants' responses revealed that various personal, interpersonal, and environmental factors either facilitated or hindered their adjustment or adaptation to the work environment and that they experienced certain stages of adaptation. For example, they initially felt some anxiety, uncertainty, and/or enthusiasm about their performance in the work area. Later, many of them faced a reality shock:

> When we were graduating, we had so many anxieties and queries because we were from the first cohort of the BScN program. So we were a little bit scared and fearful as well, that we don't know *ke kis type ka response aaye ga* [how they are going to take us] in the hospital. (Atya)

> We were excited that we are BScN graduates, and it will make some difference in the work environment. But once we started working regularly in the clinical settings [the hospital], we found that as such there was no difference between other nurses and the BScN graduates. (Daud)

Many of the graduates thought that they were well prepared for what they were expected to do, but then they discovered many things that were still new to them and for which they needed more competence. This was particularly the case for psychomotor skills. In addition, they found that their level of responsibility and accountability as staff nurses was much different from what they had been used to as nursing students. Therefore, these graduates went through a period of struggling and finding their way before they achieved a sense of comfort and confidence as competent professionals. However, I did not organize the data from their responses into specific stages because the current study does not aim to describe the process of becoming a competent professional. In accordance with the purpose of the question as stated above, I will categorize and discuss the responses to the question under four categories: individual characteristics, familiarity and interest in the assigned area, support and facilitation, and staff shortages. The descriptions of these categories and their subcategories, along with the participants' accounts, are presented below.

### *Personal Characteristics*

This category includes the personal characteristics of the graduates, such as motivation to learn, assertiveness, and self-confidence, that they identified as helpful in their transition. Similarly, some of their personal characteristics such as self-confidence and self-perception may have made their adaptation harder without their realizing it. Because their professional education may have enhanced some of the personal strengths, I have also included their reflections on their program, such as theoretical knowledge, in this category. Although all students in a specific program at one place would have access to similar educational opportunities, their level of knowledge or their ability to apply that knowledge in the work environment still varies.

Nearly half of the participants reflected on the personal strengths that helped them through the transition period, such as strong theoretical knowledge, an ability to reflect on personal experience, motivation to learn, or determination to differentiate themselves as BScN nurses. For example, Atya suggested that her ability to reflect on her interactions and experiences with others helped her to learn, and her determination helped her to overcome her sense of insecurity:

> I needed to learn by myself; that insecurity led me to develop self-confidence. If they [management] are thinking that we are different, so I should prove that I am different, I should set an example, and I strived for that. [smiles] . . . So those things helped me to become a good professional. One more thing: The key factor which helped me is the assertiveness, which we learned in the school. In a few areas I have applied that assertiveness, and that helped me a lot in becoming a confident professional.

Although Kiren mentioned several factors that helped or did not help, she thought that her determination and her motivation to learn were key factors in her transition:

> Let me first say, what wasn't helpful, as mentioned earlier, better psychomotor skills are demanded from you as a BScN graduate, which obviously you don't have right away because this is your first practical experience, so that was difficult. When I was taunted for my competence in psychomotor skills, I felt discouraged, though I think that it was a positive criticism. But that is something that I can never forget; it is kind of fixed in my mind that I was told this . . . . Because of that, I was literally hesitant whether I should ask a question from this person or not. Then I thought to myself, avoidance is not going to help me. Why not ask the same person to teach me who is commenting [on me]? And I said, "Show me how you do this." So after three months I had learned that [skill], and I knew what to learn from whom and when. So in terms of helpful, [it] was my motivation to learn. I was motivated to learn and show them that I am also an AKU-SON graduate. I wanted to remove those labels that "She is a diploma, and she is a BScN." Later I got support from colleagues, and that was because of the motivation that I demonstrated [to them].

Hirah appraised her self-confidence and the theoretical knowledge that helped her to work independently:

> After a week of supervision by the NES [Nursing Education Services] instructor in which she certified us [Hirah and another BScN nurse] for medication administration and IV [intravenous] cannulation, we were assigned to work independently. The diploma nurses who joined the unit with us, they were buddied for a week with senior nurses, and we had an independent patient's assignment, but we were working confidently with the patient. We had good theoretical knowledge and clinicals in our program, so we were feeling quite competent; we were able to rationalize what we were doing. We were very assertive in our work environment as compared to diploma nurses . . . . For example, one day in my initial period on the unit I noted that my patient was getting potassium chloride, but his lab result for potassium was normal, so I called

> his doctor and asked him why this patient is getting the drug, and the doctor said that it should be discontinued.

Likewise, Anum also thought that her theoretical knowledge helped her:

> So the things that were helping, basically, it was the theoretical knowledge. What I think personally is that the theoretical knowledge which I acquired from the four year BScN was good; it helped me a lot to interpret and to interrelate things [in practice]. Sometimes the clinical experience was also good, but sometimes the hands-on practice was not that good, which could be the same for diploma program too. Generally, I did not have much difficulty; I have not faced much difficulty to adjust to the environment.

### *Familiarity With and Interest in the Assigned Area*

This category consists of the informants' reflections about their familiarity with and interest in their assigned area of work. Almost all of the informants commented on their familiarity with and interest in their assigned areas. They found it helpful if they had a good exposure to their assigned areas through the senior electives or if they had a good orientation on that unit. On the contrary, they did not find it helpful if they were assigned to an area in which they were not interested and if they did not have a proper orientation in that unit. Hence, I will discuss the narratives of the informants under two subcategories: senior electives and orientation.

#### *Senior Elective*

Students at AKU-SON indicate three areas of preference for their senior elective in the hospital, and the faculty of the course then assign the students to various units based on the number of preceptors available on each unit. Therefore, students usually fulfil their elective in one of their preference areas. However, this does not guarantee that upon graduation they will be assigned to the same unit where they did their electives, because in the hospital, staff are assigned based on the unit's need rather than the staff's preference. However, among a few others, Huma was assigned to the same unit where she had completed her electives:

> In the final year of the BScN program, we had to do an elective [practicum course] in a specific area. I had chosen [unit name]. Fortunately, as a new graduate I was assigned to the same area; therefore, I adjusted to the environment more quickly than my other classmates. Having an elective on the same unit before graduation was helpful for a smooth transition, plus having a good

> preceptor made me comfortable on that unit because it lessened my anxiety. I knew the work environment, I knew the co-workers, and they knew me, so I could adjust easily.

Huma also compared her transition experience with that of her sister, a diploma holder who was assigned to a unit that was not one of her preferences:

> She cried almost every day for the first six months, whereas I used to be very fresh and wanted to do this and that. So I think my elective on the unit was helpful. She [Huma's sister] could not adjust to the environment and workload, and people used to comment on her, that she can't do this and that, although she thought she was doing her best . . . . She thought there was too much to do in her unit, though sometimes on my unit we were also very busy, didn't have time for any break, or even stayed here [on the unit] for twenty-four hours. But I think I was mentally prepared to work in this area, and my sister was not prepared for her area.

Likewise, Komal reported:

> I did my senior electives in the [unit name], so it helped me. Before joining [the unit], I knew what type of staff work here. What are their qualities? What is their mentality? What are the areas for improvement? For me, it is not something difficult to work with them or to adjust to the environment like for others, as it is their first experience with the staff with the unit, so it is very difficult for them to adjust to their work environment. But for me, as I already knew what they expect of you, so how to work with their negatives which may always hinder you in your work, so I knew how to handle this . . . . For example, you should know everything. Once I asked for the drug-error policy, and the response was, "We expect you to know this."

In addition to others who had completed their electives on the same unit, Huma mentioned that "expectations were higher as I had my elective on the same unit." Yet, in her view, the advantages outweighed the disadvantage, and "I will suggest that one should be assigned to the same area where one has done the elective."

However, Hamid was not as fortunate as Huma and Komal. He reflected on his disappointing experience and made some suggestions:

> I did my electives in [unit name], and that unit was my first preference for work too. [Unit name] and [unit name] were my second and third preferences. I requested that the nursing management transfer me to one of my preference areas. They didn't assign me to any of my preference areas, but rather to another unit, so I wasn't happy there. From the very first day I knew I will resign soon. I didn't like that area in my experience as a student there, so that's why I was not

> comfortable there. I tried to adapt to the environment, I tried my best to adapt, but I couldn't . . . . After three months on that unit I resigned. Then the manager offered me to transfer me to one of my preference areas, so I changed my mind, and I was looking forward to [date of transfer]. [However], when I went there to report, the HN said to me, "Who told you that your assignment has been transferred to [unit name]?" I felt very disappointed and resigned with twenty-four hours' notice . . . . I think if the [management] ask us for preferences, then they should respect or regard our preferences to have good output from the individuals, which will be helpful [to all].

Unlike Hamid, when Aneel was not assigned to an area where he wanted to work, he made no effort to adapt, but resigned with 24 hours' notice during his orientation period. On further exploration, Aneel revealed that he had had some bad experiences in that unit as a student, and he felt uncomfortable even trying to work there. Furthermore, Aneel asserted that he had been treated unfairly. To support his assertion, he explained that many of his classmates had shared information about where they were going to work even before their orientation had begun, and they were sent to those areas when their assignments were announced. Aneel wondered "how did they know in advance about their assignment. Certainly there is favouritism."

Although Adil was also not assigned to the same unit where he had completed his elective, he was able to cope with his work assignment in a critical care unit after some fear and anxiety. It is important to mention that, unlike Hamid, Adil had better support from his friends and colleagues. Moreover, Adil had prepared himself differently than Hamid:

> When I graduated, I had a plan that I will join the same [AKU] institution, . . . and whatever placement they [management] give me, I will go to work there. They placed me in [name of the unit], which was tough for me because as a student I had had only three to five days of clinicals with my teacher in this area. At that time my teacher was with me, so I had all kinds of support from my teacher . . . . So I had severe kind of anxiety because of my limited exposure in this area. I was not sure whether I would be able to adjust here or not. Whenever I came on duty, I had some sort of fear in my mind: "How will I do this and that? What kind of patient may I get?" And especially I was very fearful of handling a crash [cardiac arrest].
>
> I talked to different people in my friends' circle, and I talked to some people in the critical care areas and my senior colleagues, and they kept advising me on what to expect and how to address things . . . . I just tried to be patient and remain calm, though it was a tough area for me because I was a fresh graduate,

> and their expectations were high according to that area. That's why I had to work hard.

Diya got her first area of choice for her elective, but she wasn't assigned there as a staff nurse, she recalled:

> I did my elective on [unit name], and I liked that area. In my mind I was prepared that probably they were going to offer me this place [to work] because I worked over there and found it very comfortable; it was within forty days. I had a good rapport with the staff and learned many new things in that area, but I was put into [unit name], and I was disappointed, . . . so I had to start my efforts all over again. It was a shock.

When I asked Diya if it would be better for the faculty to know in advance about the vacancies on each unit and then arrange for the student electives accordingly, she replied:

> Yes. . . . But if I had been randomly selected for my senior elective for another unit not of my choice, then it would have been very difficult for me to manage my course, thinking that I will be working in an area that I don't like, and such anxiety would have spoiled my learning in that course as well.

Kiren was also not assigned to the unit on which she had completed her elective; however, she was very happy with her assignment:

> Usually you expect to be assigned to the area where you do your elective. I did my elective at one place but then was assigned to another area, but I felt good because [unit name] is my preference area, which is a big motivating factor for me [to work here].

In general, it was beneficial to the graduates to be assigned to the same units on which they had completed their elective; but more important, they found it difficult to adjust to a unit if they did not like that area.

### *Orientation*

Many of the participants talked about certain aspects of orientation both positively and negatively while reflecting on their transition experiences. There are two phases in the orientation at AKUH: the staff nurses' two-week orientation from the nursing education services (NES) and the unit-specific, competency-based orientation (CBO). A CBO checklist is given to staff nurses after they are assigned to a specific unit, and the time they are allowed to complete the CBO checklist may vary according to the specific unit's requirements.

Anum, Adil, Bilal, Hirah, Daud, and Kanwal had had two weeks of orientation from NES, whereas Komal had had only one week orientation, and Aamna had had only three days. Initially, most of the graduates were scheduled to work only on the morning shifts (before moving to their rotating morning, evening, and night shifts) to familiarize themselves with the new work environment as well as to benefit from more opportunities for supervision on the units from the head nurse and the clinical nurse teacher. However, the length of time on the morning shift was not consistent for all of the participants. For example, Diya and Kanwal had a month of morning shifts before they began shift duties, Hirah and her other BScN colleagues had two weeks of morning shifts, Komal had one week, and Aamna was assigned shift duties immediately. Moreover, implementing the CBO seems to have varied, as indicated in the participants' narratives. For example, Kanwal, on a critical care unit, had an enabling environment and supportive colleagues and supervisors, which facilitated her learning from the CBO checklist:

> We had a CBO checklist that we were supposed to complete with our CNT [clinical nurse teacher] or TLs [team leaders], so we had to work accordingly. We were given the opportunity to work in all areas of the unit. There were certain skills that we needed to perform under the supervision of the CNT or TLs or they needed to show us how to assist. We were given exposure to everything that happens in our unit. That was very helpful. I mean, the CBO is a very nice idea. In that way, though I was a junior, I was given all kinds of assignments to learn . . . . If we had to see a chest tube insertion, we were given the chance. Anybody would come to us—maybe a colleague, the CNT, or the head nurse—and they would say, "Okay, I'll do your work. You go and see how the chest tube is being inserted because you need to know the things that you need to arrange before the procedure and what is the role of a nurse in that [procedure]." And when there was a crash situation—the patient was having CPR [cardiopulmonary resuscitation]—they used to tell us, "Leave everything; we'll do your work. You go and watch that." And that was really helpful. People in my unit are extremely helpful; they have created an environment where everybody helps everybody. So that's the way the helpful environment in the unit is very helpful in terms of learning.

In contrast, the CBO orientation for Aamna was not helpful; she had the CBO long after she needed it. Furthermore, unlike other nurses, Aamna had the shortest NES orientation:

> Usually NES gives one or two weeks' orientation, I think, but because there were few of us [three, all from the BScN program] who took the second orientation [sequence of orientation offered in the fall], we were given orientation just for three days. So that was a drawback for me that I had only three days of orientation. Everything was condensed into those three days, which was a very limited period . . .

Proper orientation for the unit is important, because if I reflect on my experience, I had no formal orientation on the unit, but after one and a half or two months on the unit, I was given a checklist, a CBO checklist. I was asked to complete that orientation checklist, which should be completed in the initial few weeks so the staff would know where things are kept on the unit. [Initially] I was having difficulty in locating things on the unit, so it wasn't helpful to get that CBO after one month to one-and-a-half months on the unit.

In addition to Kanwal's and Aamna's contrasting experiences with the CBO, Kanwal worked on the morning shift for one month before she was given rotating shift duties, whereas Aamna began shift duties immediately. Coping with shift duties in itself requires adaptation because the circadian rhythm is constantly changing; hence, adaptation to the new role, new environment, and shift duties together could be difficult for a novice nurse.

In general, although all of the participants had received some form of orientation in the hospital before working as staff nurses, there were wide variations in their experience of orientation.

### *Support and Facilitation*

This category is comprised of the participants' experiences in regards to the support and facilitation from colleagues and management, which they viewed as another key factor in their transition. Each informant referred to the kind of support and facilitation that they had received in their transition. In general, many of them indicated a lack of support, although a few of them had benefited from a mentor and role model, such as a CNT or a senior colleague on their unit. As discussed earlier in this chapter, management and colleagues had high expectations of the BScN graduates; therefore, they thought that the graduates should be able to work independently with minimum facilitation and supervision. Moreover, there was tension between the BScN and non-

BScN nurses, including post-RN BScNs. As a consequence, some of the graduates had to learn by themselves through trial and error, whereas others had partial support from their colleagues and/or management, as many of the informants revealed in their narratives.

***Colleagues***

As described earlier, Adil and Kanwal had received good guidance and support from their senior colleagues. Likewise, another participant from critical care observed:

> The staff was very cooperative, they were very helpful, especially the senior ones. They were very helpful and very supportive, except a few, but it happens everywhere. Overall, they were very supportive, and even the management was very supportive. Therefore I learned in a very limited time. I learned all the skills in two or three months and then started taking patients individually, so that was very good.

Although the management supported and encouraged Bahaar in her work, she was discouraged because she had not found her colleagues helpful in her transition. She suggested that, in general, the work environment on her unit was not enabling as a result of the lack of cooperation between the staff and management:

> The staff were not happy about their workload, and they used to threaten management that they would resign in twenty-four hours. So that's why a junior staff like me at that time would end up doing double duty, because the senior staff wouldn't agree. Moreover, many of the staff used to take shortcuts in patient care and wanted me to do the same. They would say to me, "You are very new; you are a fresh graduate; that's why you are motivated and enthusiastic despite your workload, . . . but you will not be able to continue that."

Hirah was not happy with the management, but she acknowledged the support of her team, especially the team leader, who became her mentor and role model:

> At that time we wanted a supportive environment, including support from management, but that support was not there. My head nurse was not supportive to me, but the staff around me [colleagues] were very supportive. For the first six months I had a chance to work with the same group of staff. The team leader in that group was excellent. I didn't learn anything from others, not from my head nurse and CNT, except from her. She was a great mentor for me, and I will never ever forget her. The first six months were very precious to me, and she taught me everything. She was very quick in dealing with patients and handling different situations, so I learnt that from her, and what I am now is because of that first six months of her teaching. She was an excellent role model and excellent mentor.

To the contrary, Kiren lamented, "In the initial three months you feel that all of them [colleagues] are there to tear you apart. The first week was tough." Similarly, Arzu reported:

> New nurses were like foreign bodies on the unit. We were bullied by our senior colleagues; the lack of teamwork was evident. I could see a different attitude toward all the junior nurses, regardless of which program we came from . . . . Then a time came [when] we started to respond in the same language; respect and manners vanished [*disappeared*] . . . What I have been observing for the last three years of my career is that the most oppressed person becomes the oppressor; hence, the cycle of oppression continues.

Because of limited support from their senior colleagues, Aisha and Aamna noted that they used a trial-and-error approach to their learning. Similarly, Atya explained:

> Behaviour of the senior nurse colleagues was not helpful, especially when they were in the majority and you were the only nurse from a four-year BScN program. Senior nurses had a very strong negative attitude towards us, to a level that it was a hindrance to our learning, so I tried to learn on my own.

Bahaar and Komal alluded to some principles of interpersonal relationships that helped them to seek collegial support in their transition. Bahaar observed:

> There were a few colleagues, they were not RNs, but they were midwives [RMs], and only a few of them, one or two of the midwives, were quite helpful, though they were not someone who used to come on their own. But when I used to greet them and be with them and helped them with their heavy workloads, they would feel good, and then they would help me in things like where I could get this thing from and how to operate this equipment; they used to teach me all those things . . . . They used to feel good that "she is a BScN graduate, and we are teaching her," because in my unit there was discrimination between RNs and RMs. The RNs used to feel superior to the RMs, but I felt that some RMs were more skilful than RNs because they had many years of work experience on that unit.

Komal added:

> I greet them very respectfully. I also do their work. Whenever I need their help, I ask them and politely say, "Will you please help me?" [speaks softly] So the staff never said no to me because in return I also do their work, so it is a give-and-take situation. If you do something for them and respect them, then they will also help you.

Among others, Komal, Bilal, and Huma reflected on the prevailing issue of the high turnover rate of nurses at AKUH and its effect on the level of facilitation for novice nurses:

> There is a high turnover of nurses; nurses are resigning, so we are losing skilled workers, and then there isn't that passing of knowledge from the experienced nurses to the novice nurses. So when we came in [to the unit], basically we had one other senior nurse who had a single year of experience over us. Previously, we had nurses on ### [unit name] who had three or four years of experience each, and they all left or resigned due to whatever reasons, or personal reasons, before we joined in, so we lost all of that knowledge. There wasn't that passing of knowledge from them to us. So probably if we had come into contact with them, things would have been different. We would have been facilitated better; we would have learned more.

Huma's reflection coincided with Bilal's: "Unfortunately, when I came on ### [unit name], my preceptor had left [resigned]. No one taught me further as he used to do, so my learning and growth stopped. He was a very experienced nurse and role model for me."

As noted earlier, AKUH seems to have more novice nurses than experienced nurses. As a consequence, novice nurses may receive limited facilitation from their colleagues, particularly if a novice nurse is expected to mentor another novice nurse, as I described in my field notes:

> Deena, a nursing intern, joined this unit a week ago. Today she is buddied with nurse A, who has five months' experience in the profession. At one point nurse A was required to do a procedure that she had never done before, so she approached other colleagues who are comparatively senior to her for help while Deena was watching the patient. One of the nurses responded, "I am assigned to a small child while your patient is in isolation, so it could be risky for my patient. It will be better if you can call someone assigned to an adult patient. However, if you find no one, then I will come." During this time, the CNI of the unit was busy supervising other interns for medication administration. When I asked nurse A, "What will happen if you don't find another senior colleague to help you?" nurse A responded, "I will have to wait for the CNI till she finishes her work with other interns." (PO, May 5, 2006)

In view of this situation, it is not difficult to imagine the quality of the support that nurse A would receive from Deena.

In addition to the above experiences of the graduates, for two informants, gender of their colleagues also had some bearing on their learning ability or level of comfort in their transition period:

> When I joined here [the unit], there were not many female nurses here, most of the staff were male, so I used to feel very anxious and afraid of working in an area that was male dominated. I was fearful whether people would accept me or misuse me. There was a sense of insecurity because of working with male colleagues and odd hours. [Name of the unit] is a very closed [isolated] area. I was harassed by a male staff who is not there anymore, but at that time, I used to be very careful in working with males. These were the kind of things that I couldn't share with my mother but kept thinking about it as "what will I do if some thing happens." But now I am very comfortable in that area as I have spent some time there and I am safe [laughs].

> In my unit, I was the only male nurse, the rest were female, so I used to be a little cautious [in interacting with them]. Because, there were no male colleagues, it was difficult for me to find someone to look after my patients when I wanted to go for my prayers. So maybe it was also a contributing factor for my inability to adjust there.

***Supervisors***

Three informants, all from critical care, acknowledged the support and guidance of their management. For example, one of them stated, "The CNT [clinical nurse teacher] was there. She helped us a lot as she helped anybody else. There was no differentiation between us and other graduates [diploma] from the CNT." Likewise, another informant was encouraged that her head nurse and physicians trusted her:

> Because of my elective and good preceptor, when I began my work life, I worked as a staff nurse within a week or so. Most of the physicians trusted me, and the head nurse trusted me. My three-month observation period [the probationary period] was excellent.

Unlike some of the informants, Diya shared many examples that indicated that she was being pushed into challenging circumstances without receiving any acknowledgement, such as working as a team leader within fifth week of her work as a staff nurse. Although Diya was willing to accept the challenges, she was disappointed and frustrated with the lack of guidance and support from the head nurse, as well as her language: "'*Tum bewaqoof ho* [You are stupid].'" That word *bewaqoof*—stupid—irritates me. I have my self-esteem, I have my self-worth, so this is not helpful." Moreover, Diya complained that, on one hand, she had been assigned to work as a team leader, but, on the other hand, she was not given the opportunity to attend some of the courses that were relevant to the role of a team leader. When I asked Diya, "What is the policy to be a team leader?" she identified three requirements: certification in Advanced Cardiac Life Support (ACLS), a course in team leadership, and at least one year of work experience. Upon further exploration, Diya told me that these requirements are not explicitly stated, but that people know them, and she gave me an example to support her claim: "Team leaders are certified in ACLS, so a few days back I asked my HN when I will be sent for ACLS. She said, "Not until you have one to one and a half years of experience."

Later, during my observation on the North Unit, the head nurse also reported that, although there are some requirements for becoming a team leader, many times "we have to waive it because of the staff shortage." Likewise, Saher, one of the supervisors, said:

We have a practice here that a nurse shall be assigned to the team leadership after one and a half to two years of experience. But looking at the current conditions and the average turnover rate, it is very difficult for us to abide by that rule.

Komal shared her experiences in an interesting manner. She reflected not only on her experience, but also on how a supportive head nurse or CNT might facilitate his or her staff through the transition:

> I feel that if a head nurse is very good with you or a CNT is very good with you, then they would help you to go through this transition period [smoothly] . . . . [For example,] even if they do your counselling they will ask you, "What do think about this unit? What are the things that upset you, or what are your difficulties? Do you suggest any change in this setting? and this type of talk, when you are able to verbalize your feelings with your CNT or the head nurse, helps you to work with them. But if the head nurse and CNT are not very cooperative with you and they always fill an observation form for you or they scold you in front of the other staff at the reception or in front of the doctors, then these are the negative forces that will suppress your skills.

Following the above narratives, I asked Komal, "Are you talking in general or talking about yourself?" She replied, "Both. The CNT never scolded me, but others did." On further exploration, Komal revealed that, recently, management had filled out an observation form about her four times:

> Yes, four times in one month . . . . I don't understand it. When you fill out an observation form, the policy is that before filling out the observation form or the yellow form [incident form], you [management] should discuss it with your staff—what are their mistakes and what are the areas for improvement?—and then warn them that if the same mistake is repeated, then an observation form will be filled out.
>
> My second observation form was filled out because I had not written the NCPs [nursing care plans] on a flowsheet, which you are expected to do at the end of the shift . . . . I was very busy during the whole shift, and I didn't get the chance to write the NCPs, so I knew that I had not written the NCPs. Usually, if we are not able to do a certain task, then we have to inform the head nurse or the CNT; and if they are not available, then the team leader should be informed that we are not able to do this [task]. Otherwise, the next day, when the manager comes, they wouldn't listen that you were busy . . . . So I told my CNT that I couldn't review the NCPs, but even then on the next day she told me, "Come to my office and sign the observation form, because you have not written the NCPs."

### *Staffing Shortage*

This category consists of the informants' experiences related to staffing shortage and its negative implications their workload had in their transition. Almost all of the informants commented that the staffing shortages on their units led to increased workloads in the form of responsibility for more patients, or they that were required to take on additional responsibilities sooner than was the usual practice. As noted earlier, some of the graduates were required to work as team leaders within the first three months of their work on the unit. Similarly, many of them were required to work double shifts. Although having to work double shifts is a common issue for all nurses at AKUH, the new graduates found it overwhelming because they were trying to adjust to their new role of staff nurse.

#### *Workload*

A number of graduates reflected on their patient-care assignment and alluded to their workload. For example, Komal recalled:

> On our second day on the unit we were assigned patient care independently. One week we were doing patient care except for their medication, in the second week, we were certified for the medication, and then onward we were doing everything. If you get ten patients, then you have to do everything for them, including their medication; and if you get fifteen patients, then you get a CCT to help you with their basic care.

Komal also indicated that one may have fewer patients if assigned to special care, but it does not mean a lighter workload. She elaborated that on the special care unit the capacity is five patients. Usually the census is 100%, and all the patients are highly dependent for nursing care. The RN working on the special care unit is supposed to be an "all-rounder." She has to be responsible for direct patient care and coordination of the care with physicians and support services; management of new admissions and the transfer of patients in and out of the unit; and all non-nursing functions such as counting, recording, and refilling the unit supplies, including stocking medications, the crash cart, and medical/surgical supplies. Komal revealed that although according to the policy a senior nurse and a senior CCT should be assigned to the special care unit, because of staff shortages, a novice nurse and a nursing assistant actually manage the unit.

Aisha further illustrated the workload that she was expected to manage:

> When I started there, usually we [one female nurse with a male CCT or NA] had to care for ten to twelve patients—five male and five female patients in a Neuro block. Plus, because the staff was always short, we used to look after the patients in the semiprivate room, usually two rooms with two patients in each room. So you would have fourteen patients. Sometimes you might have a separate nurse to do your medications, but other times you also needed to do your medications besides everything else. In the case when your patients in the semiprivate rooms were female, then you would have eight or nine female patients to care for besides medications for all patients, because CCTs can't do that. Patients with neurological problems usually require high-dependency care because they may be paralyzed and or have a low GCS [altered conscious level]. So if you are working with such patients, you are expected to change their position every two hours and give basic care—mouth care, eye care, or backrubs. Such patients usually require frequent suctioning, and they require strict monitoring of their condition. Some of these patients with high ammonia levels receive lactulose [a laxative], and they require cleaning every one to one and a half hours. Furthermore, as a nurse you are also required to take care of new admissions if you have an empty bed; you need to do the detailed assessment as well as orient the patient [if conscious] and family. And if you are doing the medication administration with this level of patient care, writing the nursing notes, and dealing with all the other patients' concerns, it is difficult to manage with one nursing assistant.

In addition to the number of patients, the above excerpt also identifies gender-specific care as another factor that may increase the workload of a staff nurse who has patients of the same gender as the nurse but an assistant of the opposite gender. It is also worth mentioning that most hospitals in Pakistan have separate units for male and females patients. Hence, it is comparatively easy to deal with some of the staffing issues. However, at AKUH the units are not separated by gender, but within each unit the patients are segregated by bays—a block of five patients as described in Chapter Four. Similarly, in a semi-private room both patients must be of the same gender. Hence, patients may be moved around from one room to another to maximize bed utilization and demonstrate respect for the cultural value of gender segregation. Although invisible, it creates more work for the staff when they move a patient from one room to another.

In Aisha's view it was not possible for a nurse to manage this workload and do the job effectively:

> Initially, I said to my head nurse, "It is not possible for a nurse to do everything on time with this workload." she said, "For fifteen years we have been doing this; you will also learn how to do that," and then I did it. [loudly and sarcastically] I was neglecting some of the patients, ignoring some of the calls; you have to rush for the medications and everything else you are doing. If a patient was asking for cleaning, I would say, "I need to give a medication; you have to wait." Because I had no extra staff who could have helped me, they had to wait. The tasks were done, but not in an effective manner; you cannot give maximum time to the patients. But they [management] said, "Everyone is doing it; you have to do it," and I did that! I just dragged myself, ignoring some of the patients and ignoring some of the tasks.

Adil did not have as many patients as Aisha or Komal had, but time management was still an issue for him:

> Sometimes they want more from you on the very first day or in the initial period. At that time I would be confused and helpless [because] "this is my initial period and they want more from me," so I didn't know what to do . . . . They would give me some sort of a plan, delegate some sort of work: "From eight a.m. to ten a.m. you should do this, and then come and report to us that you have done this, this, and in this manner." But I had my limits in terms of time [management], so then they would call me to say, "You haven't done this. It's ten-thirty, and you should work fast!"

Although Kanwal appreciated her colleagues and supervisors, she echoed the opinions of others about their workload:

> When you are the only nurse over here who has to do medication for ten patients and cannulation of ten patients, probably out of those ten you have to do three female catheterizations, and the workload doesn't help us because sometimes I feel that it is only the work that I am doing and no learning. I am good at my

> skills, but what about this? What about that? I don't even know if my patient has Parkinson's disease, and why is that a cause of this shortness of breath, or why is that happening? I mean, sometimes I really feel that my learning is being hindered because of the workload. It's like fifteen days passed by, and I haven't learned anything new. I am very good at my skills, very speedy [smiles], but I don't know what is going on around me.

Bilal explained that working as a staff nurse is much different than working as a nursing student. As a staff nurse one is required to work independently and spontaneously; however, novice nurses need time to think through their actions before doing them to avoid mistakes, which becomes difficult if the workload is high:

> While we were students we had faculty members, we had nurses, with them looking out for us or who were behind us, and prevented us from making any mistakes. But when we got our credentials and we got our license and we got our degrees, that meant that we are supposed to be responsible for the patient. If anything happens, we are blamed; we have to take the responsibility. So learning to cope with that was extremely difficult, and working in the ### [name of the unit] at those times was also very difficult. We had sort of crises in the sense that we had seen increased patient-influx situations, . . . and to us it felt like we were being overloaded. And sometimes, initially, we were asked to do double shift. Sometimes it was shift duties back to back. We would go home and collapse and then didn't know where time went.

Like Bilal, Daud also commented that he had not realized the actual workload of a nurse until he began to work independently as an RN, because students work under the supervision of faculty or staff, and it is accepted that they do not "feel comfortable doing certain things. But once you start working independently, you have to do it; you need to learn how to manage everything, so it is a high workload!"

Some informants, including Aisha, Arzu, Bilal, Hamid, suggested that documentation also adds to their workload. For example, Hamid observed:

> If I started my medications at one o'clock, it would go for two to three hours, I was hardly finish by three o'clock, because not only is it the administration, but it is also a lot of documentation for the medication work, so I used to miss my lunch and my prayers to complete that.

Some participants also noted the undue emphasis on documentation rather than on patient care at AKUH, which they believed alienates some. For example, Komal reported:

> They [management] wouldn't listen that you were busy, and you didn't get the time to document or you were not able to manage your time efficiently. What they are interested in is seeing whether you have documented or not documented. If you haven't documented, it means you haven't provided the care to the patient.

From Arzu's perspective, paying attention to the minute details of documentation was far less important than dealing with patient care, which was at risk because of the staffing shortage. She expressed her feelings with a question:

> Considering the current situation, our primary goal must be to focus on patient care, but we focus more on the documentation and not on how much work is being done for the patients' benefit. You could do that [focus on the detail of documentation] in an ideal situation where you are working with very good resources and good manpower. But if you are working with the very limited manpower in which you have tremendous workload, you have full senses with high acuity, you have a lot of novice nurses or people with compromised competencies, senior people have left because they were paid less or they got a good opportunity elsewhere. It is difficult to find the time to document. Despite these limitation of your work environment, you check for things like your signature in the documents and you say "you have put the line here but not there, out of five, you have reviewed four NCPs, but not one." So, I don't consider these things as a rationalize way of working."Tell me, where would you spend your energy when you are so short staffed—doing the care of patients or worrying about how you did your signature, you missed this dot, and you didn't draw this line?"

The following comments from Aisha indicate that, although the graduates acknowledged the importance of documentation, the values of BScNs and their supervisors differ on setting priorities for documentation:

> I prefer patient satisfaction to [writing notes]. As I said before, people judge you on what is written or things that you have documented, and they never see if you have really fulfilled all the patient care needs. But they will see how many notes you have written and at what time they were written, and if you have given medications whether they were given on time and whether all the documentation requirements were being fulfilled or not. So it was difficult. I always lagged behind in writing my notes because my priority was to care for the patient first and then take care of the documentation. I used to write my notes after my duty timings [after the shift], and I always missed my van [transportation].

As for Aisha, documentation was a second priority for Komal:

> I know documentation helps to maintain standards, especially when the hospital is going for JCIA [Joint Commission for International Accreditation]. It saves the

> hospital from litigation, and it can also save the staff from litigation, but my first priority is to give care to the patient, and my second priority is documentation. Whether I'm able to document or not would not bother me, but for sure it would bother my head nurses or my CNT. It would not bother me at the end of the day when I go home if I provide the care which my patient needed, so I would not have any negative feelings that while I was busy documenting things…. my patient care was neglected. What I feel, for me the patient is the priority, basic care is the priority; and for my head nurse and my manager, documentation is their priority.

However, Bilal offered a different perspective from the others with regard to documentation versus basic patient care:

> Giving basic care to fifteen patients is a tremendous task; any person would become tired, especially if one has to perform his other tasks, like performing other tests and procedures, administering medications and hygiene care, so one has to prioritize all those things. Hygiene care does come slightly lower on the priority; there are things that are more important. The hospital places a lot of importance on documenting care because we often hear that things that are not documented are not considered done or performed. And then documentation has a lot of legal implications as nurses' documentation may be taken to court and may be used as legal evidence. Therefore a lot of emphasis is put on documentation. Hence, hygiene care or physical care does come slightly lower in priority.

Nonetheless, documentation seemed to be a contentious aspect of patient care at AKUH. Concerns related to documentation were not only debated among the BScN nurses working in the hospital but also by the prospective BScN graduates who had had completed a senior elective course at the end of their program. As a requirement of this course, each student was supposed to present a nursing practice issue that they had identified in consultation with their preceptor in the hospital:

> A number of students' presentations of their focused on the issue of documentation in AKUH. They identified how nurses are overwhelmed with documentation; some nurses do their documentation before the actual care/task. Some nurses even do false documentation, for example, they may not actually do patient and family teaching but tick off certain items on the multidisciplinary teaching form to show as if they were done. In a presentation about the gaps in records, such as "patients' fluids intake and output," the presenter shared that at times nursing staff may record the amount of fluid in the patients' charts/files without actually seeing and measuring it but based on approximation or assumption. For example, "last time the patient passed so much milliliters of urine, so it must be about the same this time." The presenters considered various factors that led to inaccurate or poor documentation, including nurses' work

> overload and lack of time, poor time management skills, lack of motivation or responsible attitude towards documentation. In another presentation about documentation, the presenter recommended that nurses need to "Focus on patient care rather than documentation." This recommendation then turned into a lengthy debate among the audience, students and faculty members. (PO, June 28, 2006)

Overall, many participants, particularly those who worked on general units, had not been happy with their workload. Their feelings were similar to Aisha's:

> Frustration was there, burnout was there, motivation was getting decreased, because what I learned from my BScN program I was not utilizing. I was very task oriented and just fulfilling my tasks. My learning was stopped; my task was just to do this, this, go and give the basic care, give the medications—just the *robotic work* that I was doing. Learning was missing, and my motivation was decreasing.

### *Double Shifts*

Because of the constant staffing shortage at AKUH, staff on every unit were being asked to work double shifts. During my observations on the units, I recorded in my field notes that double shifts resulted from staff attrition, staff leaves, and absenteeism:

> Nurse A said to nurse B, "I am doing double duty today." Nurse B responded, "You didn't do it yesterday when I asked you." Nurse A replied, "I told you that I couldn't do it yesterday, but if required, I will do it tomorrow. And see? I am doing it today." A few minutes later I asked the CNI of the unit, "Are you short staffed?" She responded, "Badly. Five people are doing double shift today." I inquired, "Why is this so?" She responded, "There are some shortages because a few staff resigned recently. In addition, some staff members are on leave for family reasons. Their reasons were such that their request could not be ignored."
>
> When I checked the duty roster for last month, thirty-seven double shifts—either morning plus evening or evening plus night—were marked. Doubles shifts are allocated to all staff, including nursing interns and the new diploma graduates who are waiting for the results of their Sindh Nurses Examination Board. (PO, April 7, 2006)

To understand the prevalence of double shifts at AKUH, it should be noted that during my observation of the North and South units, described in Chapter Four, at least one nurse on each unit always had to work a double shift. Overall, everyone, including staff and management, seemed to be distressed about the requests for double shifts, but particularly those who were learning to cope with different demands. For example, Bilal commented:

> What I found most distressing is that, as you all know, we are facing nurse shortages, so even, I think, during our initial period, within the second month we were asked to do doubles, and we were not yet through our learning phase. So at times it was like an extra burden on us.

Aisha also elaborated on the difficulties associated with working double shifts:

> If I had worked an evening shift, I was unable to get up in the morning; and if they [management] had a staffing shortage, they expected you to come to the morning shift or do a double shift, morning and evening. For me, doing a single shift was more than enough because in that single shift you have to do so much if you work sincerely. If you are doing nine hours' duty in pathetic conditions, and at the end of the shift you are asked to do double, "Then what will be your efficiency?" I would rather try to rest and come later, but people do doubles because of staffing problems.

Kanwal also commented on difficulties of the double shifts; however, she explained that sometimes staff do a double for their own convenience in addition to meet the unit requirement for staffing shortage:

> In our unit most of the nurses do double duties, a lot of doubles! Nearly every day somebody has to do double, it goes on like a circle, if I am doing a double today, I will definitely get an off tomorrow and tomorrow another nurse will do a double duty to cover for me and then she will get off the next day and it goes on. Sometimes we are doing so much double duties on the unit that we have five to seven days of time off due to us, but we can't get that time off. Sometimes people do doubles for their own convenience too, like: "I don't want to come tomorrow so can you do double for me [own plus my shift] and I will do a double on another day to cover for you. So sometimes people do it wishfully; otherwise, usually it because of the staffing shortage.

Komal pointed out that everyone has to do double duties whether they want to or not: "If for any reason the team leader requests that you do double duty, you can't say no; you have to do it." When I asked Komal, "What will happen if you say no?" she replied:

> Nothing will happen as such, but what they usually do is *key emotional blackmail kartye hai* [that they emotionally blackmail you]. For example, if there are only three RNs, they will say to you, "Two RNs will work in the special care areas, and only one RN will be left to do medications for the entire unit beside being a team leader." It is really impossible to do all of this, and, secondly, the patient

> care will suffer. You know, we all came here for the patient care. So what they usually do is that they emotionally blackmail you.

However, Diya's experience was different from Komal's with regard to double shifts. When Diya refused to work a double shift, she was reported to the manager. In her view, there would not have been any need for double shifts had the head nurse planned it better. Therefore, she resented being asked to work a double shift:

> The day before yesterday I was really forced to do a double duty in the unit. I would have done it because I have been doing it previously too, but the problem was that the roster [monthly schedule] was not ready till yesterday, already a week after the month has begun, and we had to call from home inquiring about our shifts. Then so many people were sent for the classes [inservice education], so I asked her, "When you sent so many people for the classes, you must have substituted for it. Why have you not planned it properly? You sent half of the morning and half of the evening shift staff to classes, and now you are forcing us to do a double! It is not my problem!" So the head nurse took me to the manager [and said], "She is refusing to do double duty."

The above scenario presents a good example of a BScN graduate assertive behavior, she is questioning the planning and organization skills of her head nurse. Contrary to the prevalent norms, the graduate is not afraid to speak up about the shortcoming of the unit management and its resulting consequences for the staff. However, this ability of the graduates is not appreciated as expressed by some supervisors in the next chapter.

### *Summary*

It appears that the graduates' experiences with the transition from student to staff roles have long-lasting effects. Although there were many similarities between the experiences of the graduates from the initial cohort and those of the nurses who had recently completed their transition, the level of anxiety and uncertainty was higher for the graduates from the first cohort because they had no role models in the work environment from whose experience they could learn. However, the graduates from successive cohorts, including those in the second cohort, were comparatively in a better position because they were able to reflect on the successes and failures of the former class of BScNs.

Overall, most of the graduates considered their transition a challenging process. The time period of their transition from a fresh graduate to a confident professional varied from three months to a year. Many factors seemed to influence their transition including personal characteristics, professional capabilities, interest and familiarity with their work environment, workload, and collegial as well as management support in their work environment. Moreover, the graduates were able to adjust better on a critical care unit than on the general units even if they did not complete their electives there, because in critical care areas they had an opportunity for holistic care and a comparatively manageable workload. Likewise, the learning opportunities were greater in critical care than on the general units.

## Perception of Roles and Responsibilities

To elicit the graduates' perceptions of their roles and responsibilities, I asked them three questions: "How do you find your role as a staff nurse? Is there any aspect of your role that you wish to see changed? and What drives or motivates you to work?" The informants' responses are detailed below according to three categories: roles and responsibilities, a desire for changes in role/responsibilities, and the drive or motivation to work.

### *Roles and Responsibilities*

As I reported earlier, some of the informants were working as nurse teachers when they participated in this study; however, they had all worked previously at AKUH as staff nurses. Moreover, nurses at AKUH are assigned to work as team leaders on a rotating basis on their units. Usually this assignment is based on the capability to lead the group and not merely on the basis of experience as a nurse. As I have noted elsewhere, many graduates are given the opportunity to work as team leader within their role as staff nurse. Therefore, in describing their role of staff nurse, the informants reflected on various responsibilities, including those of a team leader.

With some exceptions, most of the informants considered their work very important, responsible, and challenging similar to what Kanwal expressed: "Nursing means *sacrificing* for others. Everyone cannot do that, but only special people can do this.' And I believe in this!" However, as revealed in the informants' accounts, the value of the role of nurses as members of a health care team greatly varied depending on the area of work—particularly critical care areas versus non–critical care areas. Similarly, their perceptions of their role autonomy as staff nurses also varied.

Atya suggested that, although her role as a nurse teacher is equally challenging to that of a staff nurse, the level of autonomy has improved: "I am very satisfied, but I think that I have a big responsibility. I need to work hard to meet the students' expectations." Duad also expressed great satisfaction with his role as a nurse teacher because it gives him the opportunity for self-development in addition to applying his acquired knowledge and skills to teach and guide his students. Similarly, Aisha and Aamna referred to their roles as very interesting and challenging. Aamna, like Duad, also considered her role dynamic and progressive:

> Being a faculty member in the School of Nursing is marvelous for me. No doubt that it's very challenging when you are dealing with your students and dealing with your team of faculty. Sometimes you may have to manage difficult issues for which you may need the opinion of other faculty members. It is important to do so because you learn from each of those experiences, which can help you in the future. It is challenging, but a learning experience, because every time I do my preparation for my students or the class, I am developing.

Bahaar also stated: "My role as a staff nurse was quite enriching and challenging." Hirah, Komal, and Huma described the staff nurse role as dynamic and multifaceted. For example, Komal reported:

> I have to play different roles in the role of a staff nurse. I have multiple responsibilities; I have to do things in patient care, communicate with the supervisors, coordinate with the doctors, and linkup with staff in other units in relation to patients' admission or transfer, for procedures, etc. So as a staff nurse you have to do everything for patient care. You are not only providing basic care [using psychomotor skills], but also using many other skills, like dealing with cardio-pulmonary resuscitation, fighting for the patients' rights, monitoring and correcting the doctors' orders or the patients' drug regimen. So my role as a staff nurse is very motivating and challenging.

Komal elaborated on "correcting the doctors' orders":

> A few days ago an intern ordered half-strength Dextrose Saline at 75cc/hour for my patient. The patient was diabetic, so I said to the doctor, "We cannot give half-strength Dextrose to diabetic patients unless we neutralize it with some insulin." He said, "There is no need to neutralize it." So I argued with him, and I called the senior resident on call, and he corrected his intern. So these kinds of issues are very common . . . . Some of the interns are very good, and they take things positively when you tell them, but others would make faces or question your experience. So once when I said "three months experience," he said "Okay, three months experience! You are a very brilliant nurse!" But he said it positively.

Like Komal, Huma explained the dynamism of her role:

> I feel that my role as staff nurse keeps changing from situation to situation—like a teacher when I supervise a novice nurse, like a helper when I work with consultants, a care provider when I care for patients and their family, sometimes as a leader or a monitor when I raise issues for management's attention, or as a patient advocate when I speak for patients' rights; for example, when consults switch the timings of the patients' procedures without consulting their patients who are kept NPO [nil by mouth]. They switch the patient's procedure time based on their own convenience even if the patient has to be kept NPO for more time.
>
> Overall, I feel very proud that I am doing the right thing and I am fulfilling my job responsibilities at the end of the day. And every one or two months I take a teaching session, which gives me a sense of satisfaction because it makes me feel that I did something different. I am curious to learn new things; for example, today, after six months, I saw a procedure that I had forgotten, and today I learned. So I feel that my area is very unique, and I feel that I have lots of things to learn and do.

Huma's story reveals that she finds her work more satisfying when she is involved in teaching/learning activities in addition to patient care. Duad's reflection on his previous role of staff nurse explains why some BScN graduates seem to find their work more satisfying when they are involved in teaching/learning activities:

> My role as a staff nurse was very important because, as a staff nurse, you are the key person in patient care. It is a big responsibility. You have to be competent in what is required of you, you need to be self-conscious and accountable for what you do, you should be knowledgeable and prompt in your decision making, so it requires certain cognitive skills and communication skills. However, BScNs work hard in their program. We do so many things—presentations, projects, scholarly papers and PBL [problem based learning] tutorials—so we practice many things in the school of nursing, but we don't utilize all of these things in clinical settings while working as an RN. Working as an RN is routine work that you do; for example, morning care, transfer of patients, giving medications. I think these are very small, small things. Personally, when I did all these things, I didn't feel satisfied, I wasn't doing something different, because this was routine work and anybody could do it; this is not a very big deal. So I tried to conduct workshops to utilize my learned skills in my clinical setting. Otherwise I saw no difference in the job description and responsibilities of a diploma nurse and a BScN nurse. When you don't get a chance to apply what you have learned in your program, I guess that's why people like me get annoyed, and most of them just leave the clinical setting.

In general, most of the graduates who worked in critical care had a positive perception of their role because they were more involved in patient-care decisions or their input into patient-care decisions was often valued. In addition, they felt more knowledgeable about the ongoing situation of their patients because they worked very closely with their patients, which contributed to their satisfaction as nurses. For example, Anum maintained that, although her job was challenging, she was satisfied because she was able to provide holistic care for her patients. She highlighted various aspects of her role, including communication and coordination with other members of the health care team, as well as the application of her cognitive abilities in patient-care decisions:

> To be a nurse, I think is really a challenging task because you are coordinating things with many people involved in patient care. You have to talk with the doctors, with the pharmacist, with the people in material management and other support services, so you serve as a link between the patient and many other people in the hospital. You have to be alert for whether your patient is improving or deteriorating. You are not a doctor's handmaiden, that "the doctor has ordered this and I have to do this." You have to use your mind. If you think that what has been ordered is not right now because the patient's condition has changed, then you need to do the right thing. You can give your input, clarify things, or challenge a decision. For example, if the doctor ordered Lasix for a patient to increase his output and the patient is already hypotensive, then this is not a drug of choice; you cannot give the Lasix to this patient. Likewise, the other day when a doctor said to me, "Give 500cc of Bolus to the patient" and I knew that my patient was in renal failure—he had already retained so much fluid—I told the doctor, "Rather than increasing the volume, why don't you prescribe low-dose inotrops to help his blood pressure?"
>
> You have to be very keen to be a nurse. You have to work as a patient advocate, which is really challenging; but if you are competent and confident to perform your role, then you feel good. Though my role is really challenging, I like that because I can provide holistic care to my patients.

When I asked Anum for a specific example of patient advocacy, she responded:

> We receive many patients who are not established financially. For example, I had a pediatric patient on a ventilator for the last three weeks, and his condition was not improving. The child's mother was worried about the child's condition, but also in terms of finance: "We cannot afford to pay here." So I talked to the concerned team members and negotiated for a ventilator in a government hospital where they do not have to pay, and with the consensus of the team members, we moved the patient to another hospital. So this is an example; we go through these every day.

Adil also commented on the importance of coordination in his role of staff nurse. Moreover, he referred to the close interactions between staff nurses and their patients and families:

> I think I have an important role; I am an important member of the health care team. As a staff nurse you work very closely with the patients and their families. You coordinate with the consultants. You are constantly there at the bedside, around the clock, so you are the best person to monitor the patient's condition; you are the first one to observe and judge things and communicate with the concerned members of the team. So it is an important role.

Like Adil, Deeba also commented on the importance of communication and interactions between nurses and their patients and families, as well as with members of the medical team. She also alluded to the medical team's appreciation of her competence as a staff nurse once she had completed her transition from student to staff nurse:

> In my role as a staff nurse I have full freedom to take care of my patients and their families and explain to them or help them with whatever they are going through. In the first two to three months, yes, it was a little difficult; but since then I have gained the confidence that I am a safe staff nurse because people trust us. They recommend, "You assign [names of BScN nurses] to our patients." . . . You are responsible for your patient and kind of autonomous. You get to participate in the doctors' rounds; you get positive feedback. Doctors actually appreciate it when you tell them what your patient has actually experienced in the last twenty-four hours. So perhaps you are the better person to give such information than a resident who only comes for one or two visits. So a lot of doctors appreciate this.

Aisha's views substantiated Adil and Deeba's comments:

> I had not realized the potential of nursing until I joined the specialized area, where nurses have some independence. There they have direct communication with the consultants, with the doctors, and they have a very good rapport. When I was working in [a surgical unit], I thought there was no respect for nurses because there was no collaboration between nurses and doctors. But when I joined [a critical care unit], . . . I saw the respect that the doctors and the nurses have and the collaboration between them to deal with the patients as a team.

Both Arzu and Bilal alluded to the variation of nurses' role, between the nurses working in critical care units and non-critical care units. They affirmed that nurses in critical care areas at AKUH have relatively more autonomy to use their clinical and technical knowledge in patient-care decisions. In their views, these role differences are influenced by role expectations and working conditions, such as nurse patient ratio:

> We have many consultants who always appreciate nurses for their critical thinking, their capabilities and competence; they appreciate nurses even more than their junior doctors. Therefore, we do so many tasks that may not be the prerogative of nurses, only doctors. We give input into patient-care decisions, and let me tell you, many times our suggestions are well accepted! Definitely, we have good knowledge and we have been developed that way by our CNI. So it differs from people to people. There are many doctors who are very appreciative of the nurses in critical care areas, but not the nurses in general units because they think those nurses don't have any thinking ability. However, they [doctors] don't realize that it's not the nurses' fault. In fact, they are not given opportunities in their system; they are trained that way. Otherwise they could be performing in a similar way. (Arzu)

> Overall, in my current location I feel satisfied to a greater extent compared to the other units where I have worked. We do not have that level of workload compared with other nurses in the medical/surgical units. We are sort of expected to know a lot more than they do in terms of clinical knowledge, technical knowledge, and specific procedures. We are supposed to know each and every thing about the patient's medical history. When I see the other nurses on the general medical/ surgical units, most of them have fifteen or twenty patients at one point in time, and it is difficult for them to know the detailed history of all these patients. But we have one patient at a time, so we have more knowledge, and that sort of thing makes us feel more powerful or more important. I think, here, we have more autonomy than nurses in the general unit.
>
> If we see certain things happening to a patient, such as the patient's pressure dropping, then instead of asking a consultant, "The pressure is dropping; what should I do?" we are expected to know what to do. Fluids or drug management is our responsibility, except if there is something that needs the consultant's attention, and that's where your clinical knowledge comes in. Otherwise, you don't need to ask the consultant each and every time what to do. So you are given certain autonomy, unlike the other nurses who strictly abide by the rules. Though we also have to work within certain boundaries, we are given certain autonomy that is safe for the patient. We can use our judgment. (Bilal)

Kiren described her role of team leader and hinted that it is more challenging to be a team leader than to merely look after patients as a staff nurse because team leaders are accountable for actions of their entire team:

> As a staff nurse you have some patients and you are responsible for those patients. But as a team leader, you are responsible for everything, the whole unit. Arranging staff, even matters related to doctors is also the TL's responsibility. TL means being responsible for all kinds of problems: supervising your nursing staff,

> ensuring that documentation is complete, patients are looked after, patients' admission and transfer are handled properly. Recently, some senior people were moved from my group to another group because of staff shortages, so I pray and hope that everything goes smoothly. And when a shift is over, it is a sense of relief and accomplishment that "I have done something." However, sometimes, I feel very *baibus* [helpless] in the system despite the fact that I am designated as "team leader."

I asked Kiren if she can elaborate on what makes her feel helpless. Kiren gave me two examples, one of that is presented below:

> On the other day, the doctors continued to run a code [cardio-pulmonary resuscitation] on a patient who had no BP, pulse or corneal reflex. The cardiac monitor was showing some vibrations because all of us were touching the patient body. The resident was saying it is ventricular fibrillation while I was saying "these are vibrations only." The other colleague who was working with me was also a BScN graduate. Like me, she was reluctant to initiate the I.V line as the person was dead. The resident said to me, give the patient a shock [defibrillate]. But I was very reluctant. I think, he wanted to learn how to operate the machine. We felt it was unethical, but felt very helpless and did what the medical team wanted. The senior doctor was there too, they were running a full code on the dead body including endotracheal intubation, and drug administration, like atropine and epinephrine. I kept looking at the resident and their supervisor to stop it, but they were continuing the code. After they stopped, I said to the supervisor [physician], I understand that this is a teaching hospital, people need to learn things but this is not the way, you may learn how to intubate on a dead person, but giving shocks and drugs to a dead body, it is not right, it is not ethical, it has financial implication for the family because they will be charged for everything used in the code.

### *Desire for Changes in Role/Responsibilities*

A number of respondents identified issues that they wished to see addressed or changed, such as AKUH nurses' workload, their participation in patient-care decisions, and the nurse-physician relationship. However, unlike others, Adil was very satisfied with his role:

> No, I don't think there is anything that I wish to see changed. I am fulfilling my role's responsibilities. Ups and downs are part of life: Sometimes you have a good day, sometimes you have bad day. So there is nothing that really bothers me.

Some respondents, especially those who had teaching positions, were content with their roles and responsibilities; however, they desired to do whatever they were doing better.

For example, Aamna said, "I have limited teaching experience. I need to learn a lot, need to improve on my knowledge and writing skills so I could write more effectively." Atya added, "I think that I need to perform more competently and more skillfully. I need to enhance my knowledge and further develop my teaching skills." Hirah explained:

> In my current role we offer short courses for the staff. Each time we offer the courses, we make changes to improve them, but it is not like designing a new course or teaching a variety of subjects like a teacher does in the school of nursing. So I am interested in having that kind of broader role.

Some informants commented on the high workload and the limited time for nurse-patient interaction and care. Komal stated:

> Currently, we are working in a situation in which you have to look after ten to twenty patients because of the staff shortage, so you cannot give complete or best care to your patient. So what I want or wish to see change is the nurse-patient ratio; that is, one nurse to five patients or eight patients so he or she can give good care to the patients so at the end of the day we would not feel disappointed but satisfied.

Kanwal's views corroborated Komal's:

> About patient teaching! We have a teaching form in our documentation file, but we don't have time to teach the patient, or maybe I am not satisfied with the level of teaching that I give to my patients. It's only because we don't have time. Sometimes I even dream about it. Just last night I had a dream that one of my patients asked me my name, and I said, "This is my name." So he said, "Why didn't you introduce yourself earlier before I asked you? After doing all the work, now I've asked you and you are telling me your name." So this kind of dream [laughs] I had last night. I mean, we don't have time on my unit to talk properly [appears sad] and give time to patients. And sometimes it can really affect your patients.

I asked Kanwal if she could give me a specific example of how patients are affected by her workload, to which she revealed:

> I won't forget that day, I even cried when I went home and I was sharing it with my family. What had happened was that I had a very old patient who was quite sick. I was going crazy as I had many other patients to look after beside this patient. I was doing many things at the same time. So I started this patient on a Flagyl infusion and left to do something else while a doctor was trying to draw a sample of her arterial blood. After a while I came back to check on the patient thinking that the flagyl infusion must be about to complete, but on the contrary

> the bottle looked almost full. So I increased the speed of the drops so that it can get finished. Unfortunately, this patient was unable to speak because she was very weak, so when I increased the speed of the infusion, she just held her hand and looked at me, and I asked her if she was feeling cold and I kept rubbing her hands because they were cold. But after a while, I noticed that her infusion site was red. I wondered why because it was a fresh cannula and well in placed, plus flagyl is not an irritant drug, so I looked at the bottle again carefully and I was shocked to see it was not flagyl but ciprofloxacillin which would irritate the site if given fast. What had actually happened, was that while I was away busy doing something else, a colleague of mine noticed that this patient flagyl was finishing so she began the other medication, I mean ciprofloxacillin which has a very similar bottle as flagyl. The original label of the bottle was hidden by the label of the patient's particulars, so at first glance, I didn't realized that it was not flagyl. When I realized what had happened, I was literally in tears that "Oh my God! The poor *ammah* [addressing an old lady with respect], she was feeling pain in her arm and I couldn't even feel that. So sometimes patients' safety is at risk in such circumstances where people are trying to help each other to overcome the workload but in other way you don't get to know *who did what?*

Likewise, Aisha also commented on the workload and juggling priorities:

> I prefer patient satisfaction rather than writing up things, and people judge you on what is written, what you have documented. They rarely go to the patient's bed to see whether you have really fulfilled all the patient care needs, but they see how many notes you have written and when they were written; I mean, all the required documentation. So it is difficult because I always lag behind in the writing because my priority is to care for the patient first and then to do the documentation. I feel that there should be flexibility.

Kiren and Diya reflected on certain aspects of their role of team leader:

> I wasn't that vocal at the beginning, but now I have to be [as a TL]. If you keep on minding your own business and do not interact with your management, then it may appear that you are avoiding them, so at times you have to do something you are unwilling to do. You need to do some buttering up, which I find very difficult. At times you don't feel like talking to some people, but you have to because that person is in a management position. So I need to improve in that area. Somehow buttering up is a key point; it counts in interpersonal relationship despite the fact that you are working sincerely. So this is an area that I am weak in, and I need to improve even if I am not too keen about it. I wish to see it improved—the interpersonal aspect. (Kiren)
>
> I want to do many things on my unit, in our hospital. For example, at this point I am really interested in management work, but I want to do it properly, I mean, I should be prepared for my role as a team leader. I want a proper career ladder. (Diya)

However, Hamid was very pessimistic about his role of staff nurse. From his perspective, nurses are involved mainly in basic care, and they are constrained by their work environment, which he thought needed to change by aiming for better patient care services:

> Being a staff nurse, you have a responsibility to provide care for your patients and their families. But you can't do much because your role as a nurse is limited in the health care system in Pakistan. You don't have much autonomy in patient care decisions, but resistance from the doctors in the work environment. For example, last week on our unit a doctor ordered panadol or acetaminophen for a patient to control his fever. The patient was in hepatic failure, so I brought that to the doctor's attention and suggested a tepid water sponge instead of panadol because I have learned that acetaminophen must be avoided in hepatic failure. It could be that this doctor knew something different than me, but in response to my suggestion, believe it or not, he told me, "I am a doctor and you are a nurse!" In other words, "Follow my order."

Arzu supported Himid's views to some extent:

> At times you see things that are not done right. You can say it out loud, but it is not necessarily that whatever you are thinking will be applied. But there are so many consultants in our areas who take our suggestions; they take them well. They appreciate you, and if they don't take your suggestion, they will definitely explain why; they don't get angry about why you suggested something to them. But yes, there are many places where things are different, where you are unable to express your views in front of the consultants. This happens too.
>
> However, there is no autonomy in decision making. But yes, autonomy is there in expressing your opinion. Many times we say, "What if we do it this or that way?" and they [doctors] allow us to do so because you are giving them a rationale. But many times it doesn't happen. So it varies from situation to situation and from person to person.
>
> I think a change will occur with the passage of time. The image of nurses will change if nurses are more competent and vocal, and as they improve their knowledge, change will ensue. If the majority of nurses don't have a strong knowledge base and they are there to serve the doctors, then the general impression won't be so good. However, if you give a good rationale with confidence, your suggestions may be accepted.

My field notes of the participant observation also substantiate Arzu' experience that at times, nurses may express their opinion to the consultants but it may or may not be accepted:

> Asmah, a BScN graduate from class of 2005 was caring for a 27 years old patient with multiple fractures and lacerations including compromised respiratory status

> that was assisted by artificial ventilation. The patient's family members very anxiously going in and out of the unit. Sometimes, they came, looked at their patient through the glass partition, other times, they spoke to the nurse, if she was working outside her patient's bay. Around 2200 hrs, a team of medical doctors came to visit the patient; two of them went into the patient's bay, while others waited outside the bay. After having seen the patient, they had a short discussion among them, then one of them started writing on the patient's file, while others moved toward the unit exit. Asmah walked fast towards one of them as he was opening the door, she said something quietly to that person, in response he said loudly "that's Ok, I will tell them tomorrow before he goes to OR." Later, I talked to Asmah and inquired more about what I was seeing as a bystander. She told me that "this was the primary team [surgical] of my patient. After his assessment, the surgeon decided to have a tracheotomy for this patient because he may require artificial ventilation for a longer time. The patient will be taken for tracheotomy to OR tomorrow morning. The patient's family is not aware of this decision. I wanted the surgeon to speak to his family members now, so they can be mentally prepared for tomorrow, but you heard his answer" Asmah, also told me, "This is the most difficult team to work with." (PO, May 26, 2006)

Like Arzu, Adil suggested that not all doctors are alike because some do respect nurses' views and input. In addition, Adil affirmed that a collegial relationship between nurses and physicians influences nurses' motivation and collaboration with physicians and ultimately makes a difference in patient care:

> It varies from person to person. All of them are not alike, and they don't always react in the same manner. There are two types of persons: Some will give you a positive response; the others don't. In my view, we all are like team members; all of us work for the patients. Some physicians don't give importance to nurses because they don't recognize nurses' contribution to patient care; but others do, and they respect nurses or give importance to nurses' work. However, their approach makes a difference in patient care. If they consider your input important or respect your views, you feel motivated, and you are encouraged to work hard and to communicate with them about their patients. You can pick up on things that may not be visible and that can make a difference in patient care. Otherwise, you do your work and they do theirs; it is not teamwork.

Here it is pertinent to mention that during my participant observations in the hospital, many times I saw that nurses and doctors did not even greet each other when they came in contact, as I described it in my field notes of the different units:

> Anjum has three years experience in this unit. In addition to direct patient care, she is also working as team leader for her shift. A consultant along with his resident came to visit their patient. They were talking to each other as they

> approached the patient file, Anjum also came closer to them. However, there was no interaction between Anjum and them. The consultant and the resident went inside the patient bay, Anjum followed them and stood by the patient bedside opposite to them. At one point the consultant asked for something from Anjum, she came out of the patient bay and took a piece of paper for the consultant. Then they all came out of the patient bay and stood near a table where the patient file was kept. During this time, only once, the resident had some eye contact with Anjum while talking to the consultant. At the end, both members of the medical team left the unit without any greetings or acknowledgment of each other. After, they left, I went closer to Anjum to confirm whether I missed something, perhaps they had greeted her but I didn't hear or see it as I was standing at distance. She confirmed that there was no greetings among them and added, "some are good, but most of them are like that." (PO, May 3, 2006)

> The head nurse and a staff nurse with her nursing assistant were taking over from a night nurse. The head nurse was checking documentations of each patient, as she was listening to the information given by the night nurse. During this process, a physician with his team members (six people, all wearing a white coat) came on round; they passed by and entered a semi-private room, without any interaction between nurses and them. After a while, the team members came out of the room and went by expect one person of the team who cheerfully interacted with a staff nurse and said something to her softly about the patient. Later, I came to know that this person in the team was a case coordinator, a nurse by profession. The head nurse also told me that these days, most of the consults have a case coordinator in their team who follow the patients from admission to discharge. The case coordinator attends the physician's round and communicates with bedside nurses if there are things to be done. So the physicians [the consultants] are not required to interact with bedside nurses or the head nurse. Other than the physician round, bedside nurses and interns or residents communicate directly about patient care matters. (PO, May 16, 2006)

Bahaar asserted that nurses' image needs to change, which, in her view, will require better knowledge and good role models as well some change in hospitals, where nurses' participation in patient-care decisions should become mandatory:

> I feel that if things were in my control, I would have changed the way nurses are being projected. I think that the nurse's role is not clear to other health care professional, such as consultant or doctors. I wish to see the image of nursing changed. We need to have more good role models to change that.

I asked Bahaar "What specific things would you like to see changed in relation to nurses' image?" and she gave an example from her own experience:

> Bringing nurses into the decision-making loop in regards to patient-care decisions. Now most of the decisions are made solely by physicians, so I feel that

> at some point nurses should be involved in decisions making, and it should be a mandatory process that each and every nurse is asked to participate. I think, with nurses' input, physician may make different decisions. For example, once a resident was about to prescribe a drug, and I knew it wasn't right because of his [the patient's] allergies. I had learned that during his initial assessment on admission, so I informed the resident, "You have written orders for this drug, but the patient has an allergy to this drug." So he said, "Oh, that's good that you pointed it out; I will talk to the consultant." So I think that if nurses were part of the decision-making loop, then the situation could be different.

Anum alluded to a contentious aspect of a nurse's role that is part of nursing management's expectations; however, it may have a negative influence on the nurse-physician relationship because physicians are considered superior within a hierarchical health care system:

> There are things that the doctors are not held responsible for, but you have to tell them. For example, [for patients in isolation] you are telling them to wear a mask or wear a gown. Sometimes the doctors wear it and sometime they don't; they ignore you or give a derogatory response: "We know. You are no one to tell us that we have to do this." So I think this should be excluded from the nurses' responsibility. Doctors should be responsible for themselves; they have the knowledge, and they are adults, so they should be responsible for their actions.

When I asked Anum whose expectation it was, she explained:

> The CNI [clinical nurse instructor]. Basically, they want you to do this because ultimately it affects the patients. The CNI expects us to tell them or remind them when the doctors do not follow these procedures. The CNI presents it very positively that "you have the right to stop them and tell them to wash their hands or to wear protective devices before visiting the patient," but the doctors' reactions are not always positive. So I feel that doctors should be responsible, and if they are not, then the nurse should report it, and action should be taken. But I am very sorry to say that actions are not taken promptly when a doctor is involved, [but] actions are taken fast if a nurse is involved. For doctors, there are no criteria, nothing like that.

On many occasions during my participant observation, I noted that bedside nurses are encouraged by their management to ensure that doctors follow the existing patient care policies:

> Today, the HN held a meeting with her evening staff. She discussed various patient care related issues and emphasized on the need for compliance with patient care policies. For example: A change in policy was also announced, that is, "Medical interns are not allowed to take patient consent for surgery but

> residents or a level above them." The HN urged her staff to watch for the implementation of this policy. She added "If a patient is taken to the operating room (OR) who's consent is taken by an intern, OR staff will not accept that patient and until a resident or a person above him takes the consent." Likewise, the HN emphasized on the documentation and sharp disposal policy.... She said "No needles should be thrown in the garbage but in the sharp disposal." One of the staff responded that doctors also throw needles in the garbage and nurses have to tell them to discard it in the right place. She also shared an argument with the resident on this issue in this from her previous shift. (PO, May 25, 2006)
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> A consultant with her team came to visit a patient under strict isolation. The assigned nurse of the patient brought some isolation gowns for the medical team. The consultant opened the gown and inserted her arms in the gown up to the elbow, so it was kind of hanging on her arms. The other two people on her team followed the consultant; however, they pulled their gowns up to shoulders, so they were hanging on their shoulders, no one tied their gown at the back. After about 5 minutes with the patient, the consultant removed her gown from the arm, folded the gown, and tucked it on the wooded side rails of the patient bay instead of throwing it in the hamper for soiled linen which was kept near the entrance of the bay. After some time, a nursing assistant was passing by the bay. He saw that gown and asked the nurse "who did this" she responded "these doctors, don't you know them?" I asked the nurse about the extent of this problem. She shared that we have to tell them all the time, and added "it is my mistake that I didn't tell her that she is supposed to discard the gown in the hamper." The nurse also shared with me that last year there was a major outbreak of nosocomial infection in the Unit. All the patients were then transferred out and the unit had to be closed for disinfection. Many policies were made at that time; however, the compliance is very poor. If you tell the doctors, wash your hands, some will listen, other will turnaround and say "we know, what you do [nurses do]." (PO, May 06, 2006)

From Bilal's perspective, the nurse-physician relationship at AKUH is not collegial. It is distressing and hence its needs attention:

> I would say that the nurse-physician working relationship should be looked at. We need more respect from consultants. I mean, what they expect us to do—run after them, [wait on them] hand and foot, that sort of thing—is so distressing; it's not pleasant. . . . There are many things that we are supposed to do for the patient. I mean, we have our own responsibilities. But consultants expect us to run after them, give them things, [be] their handmaidens. I will say if things are there, "Go and get them," but they will say, "No, you give me that." So we have to sort of get aggressive with them. If they understand that we have our own responsibilities and they communicate nicely, we will cooperate. . . . A colleague of mine working in Canada told me that these things don't happen there, that they don't get yelled at or shouted at by consultants in front of the patients or in front of the patients' family members. These sort of things don't happen there; they are treated equally and with equal respect. She has given me an overview of what the

> working environment is like there, what the nurse-physician relationship is like there. It's more collegial or a partnership compare to here. The traditional handmaiden role is still present here.

It is important to mention here that nurses at Aga Khan University enjoy a better status than most of the other nurses in the country because the chancellor of the university is pro women and pro nurses. However, the chancellor's vision for nurses is not necessarily shared by physicians. Although some physicians are very supportive of nurses, to certain extent, a power issue between physician and nurses is evident. Thus it appears to be a hostile relationship rather than a collegial relationship as I described in one of my field notes:

> Today Maheen shared some of her challenges in dealing with the physicians group. Maheen revealed that some of the alumni physicians have worse attitude than non alumni physicians towards nurses. She shared some of their comments such as: "nurses are there to support the physicians" and "nurses are servants to physicians." To elaborate, she talked about a confrontation meeting that was recently held between nurses and consultants. The meeting was called by a very senior administrator at AKUH. According to Maheen, a junior nurse wrote to a physician indicating that such practice seems unethical, when a patient procedure was postpone three times for different reasons including some preventable reasons. As a result the physician got very upset and other people in the hierarchy were involved. In the confrontation meeting, there were three nurses and three doctors with extensive power imbalance. Maheen stated, that the most senior physician in the hierarchy said, "Nature has given the right to 20 years old MBBS graduate to give order to a 60 year old nurse." (PO, May 4, 2006)

In view of the above information from Maheen, it is not difficult to understand why Huma's has been discouraged about patient advocacy:

> In regards to patient rights—initially I used to fight for patient rights and I used to ask questions, but my senior colleagues told me that "they [consultant] will not listen, it is useless to talk to them." For example, many times consultants come late while patients are waiting for them for hours, but no one can question that; whereas if the consultants have to wait for 10 to15 minutes because the patient is not prepared, then consultants shout at the staff and no one says anything. So I think, it is useless to talk about patient's rights and celebrate patient's rights and family day at Aga Khan University Hospital. Though I have the potential to raise different issue and write about it in the newspaper, but I am afraid of consequences.

However, Bilal contended that the current situation of nurse-physician relationship will not change unless nurses become assertive, self-righteous, and united in their thinking:

> Nurses need to be more assertive. A lot of times you hear people referring to the doctor as "Sir," and that needs to be changed. We need to address the person by his name—for example, Dr. So-and-so—and once those things change, so will the nurses. We are directly responsible to the patient, but not to the physician. We are working with physicians collaboratively, not working under them or for them. I think we need to get away from the word *Sir*; the sir attitude needs to change. I think if nurses become assertive and fight for their rights and become more self-righteous, it will be a better workplace for nurses . . . . If one person starts speaking out about this, then he is alone and isolated, and this guy is labeled a trouble maker. So if nurses become more unified and if they begin to respect themselves and the field we are working in, then I think this change can be brought about. But some nurses still have the old thinking, that "Okay, we are there to serve the doctors" and stuff like that, so it has to be a unified effort to bring about such a change.

### ***The Drive or Motivation to Work***

Most of the informants referred to both internal motivation factors—such as altruism and self-confidence—and external factors—such as appreciation and encouragement from patients, colleagues, supervisors, friends, and family—that drive them to work. Others acknowledged that a mix of internal and external factors motivate them. For example, Anum said:

> If you are satisfied with your work, then you are motivated. There are many factors that influence your motivation: if you get a positive response or feedback from other people, if you are enjoying your work, if you are advancing in your career, or if someone just verbally compliments you for doing a good job, plus if you have an inner motivation to work, it helps.

Bilal asserted that he relies solely on his internal motivation for professional growth: "It is self-motivation; it is self-advancement. The motivation factor is myself. It is a certain drive in me to do better, to learn more. It's internal; it doesn't come from anywhere else." Similarly, Kiren explained:

> One is personal motivation and having some ideal role models, like my CNT. I always think of them and want to become like them because they are so perfect, at least from my perspective. So both personal motivation and having such ideals, you automatically develop a tendency to go on. Right now, I am not like them; I don't know how much time it will take to be like them. However, looking at them, I feel that I have to continuously improve myself.

Like Bilal and Kiren, Atya also had internal motivation; however, it was not self-development but a passion to serve at Aga Khan University: "I think this institution has given me a lot; I need to return something. I cannot return what this institution has done for me, but I can serve at least. That is the passion behind my work here."

Diya and Huma saw their motivation as their hope, self-reliance, and self-confidence and encouragement from family and friends:

> My faith, my hope that I can bring a change, encouragement from my parents and my friends, and my own belief in myself that I can do it drive me and motivate me to work. Otherwise, I can tell you that people who have left our unit were demotivated. But I still have faith and hope, and my friends and my family are helping me a lot. When I become so pessimist and everything seems so negative, then they help me to see things from another perspective, in a positive way. For example, yesterday when I was conversing with my brother, I was telling him about the challenges, and he asked me, "Did you see anything positive?" I responded, "Yes." . . . So such talks or conversations keep me going, and I am surviving. I mean, even though that area is not one of my interests, my family and friends are encouraging me that I can work anywhere. (Diya)

> At times I feel that I am tired or I feel that my job is useless; there is no growth and no promotion; I will leave the job. But somewhere inside me is a spark that motivates me to work. My mother wanted me to be independent, so I am in this profession because of her. Now I do not want to leave my independence. Another source of motivation is what AKU-SON has inculcated in me: "Do not give up." I remember one of my faculty saying to me, "You have a lot of energy and potential." Recalling such comments makes me work and grow; it energizes me. A diamond is not attractive in its original form, but special people make it valuable. I am like that because, without AKU-SON's training, I would have been nothing. (Huma)

Hirah and Bahaar alluded to a strong altruistic motive in addition to other factors. Hirah found that working with patients and teaching others motivates her to work:

> I am very satisfied with my inner self. Appreciation from patients or their family members. For example, once one of my patients died, and the close family members of the patient were crying. I was feeling helpless, but I wanted to help them. I couldn't stop them from crying because they were grieving; I couldn't do much. But I took a jug of water and offered some water to all the family members. An elderly member of that family came to me and put his hand on my head [elders' gesture of affection and caring for their young family members in Pakistani culture] and said, "Your parents are very lucky to have a daughter like you." So I was very happy. [shows excitement] I went home and shared this with my parents. They were also very pleased to know this.

Likewise, Bahaar stated:

> Helping others, seeing a positive change in the patient's condition or situation, and when I receive positive comments from my patients or their families; if I care for a patient and do something that prevents a bad scenario or leads to a good change or a positive outcome, such as when you use your observation skills and call the medical team, and it leads to a timely decision and turns the situation around.
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> And when I am able to make use of my knowledge. For example, recently I was asked to take the lead in preparing a course grid for [name of the course]. So in that kind of situation I really felt motivated because I felt that I was able to do something.

Many informants considered expressions of encouragement and appreciation from their patients and families as strong motivation factors. For example, Kanwal reflected:

> What motivates me? [thinks with a smile] I think when somebody praises me, I feel happy; and when my seniors appreciate my work, that motivates me to do better. When patients are happy, that also motivates me. Every day I get to hear something. When I hear some good words from the patients—especially when the older patients pray for you: "God bless you. You are so nice, so kind. Not even my daughter would do this, and you are doing this for me"—that really makes you feel that you are doing a very special job. I mean, those are sort of rewards, so rewards motivate me. Plus I am looking forward to having good skills. I have given myself this target of one year, and I don't want to go anywhere outside my unit because I need to learn basic skills. I think this is a very good unit to learn the basic skills of nursing.

Expressions of appreciation from patients and families also motivated Adil, and for Aamna, "Positive feedback from colleagues, the supervisor, and students helps." To the contrary, Komal was discouraged by her supervisors, whom she saw as demotivating. However, she also acknowledged that occasional appreciation from patients helps:

> Frankly speaking, nothing motivates me to work in the current situation where I am working. I have already said to my CNT and to my head nurse: "The only reason that I am working in the hospital or on your unit is because of my self-motivation, and once my self-motivation ends—which is very likely to happen because of your observations and negative feedback—then the next day I won't come to work." . . . And she said, "You are a very negative thinker." . . . We don't get much appreciation. There are only a few patients who will comment in such a way that it will overcome all of your negative feelings. But it helps that at least one patient appreciated me; no problem if others didn't. He spoke such good words about me that I really feel so good that I forget about others. It makes a difference, even if it happens only occasionally.

### *Summary*

In general, most of the informants perceived their roles as challenging, important, and responsible regardless of whether they worked as staff nurses, team leaders, or teachers. They identified and described that a combination of knowledge, skills, and attitudes are required to perform their roles successfully. Those informants who worked in critical care had a better perception of their role because they were more involved in their patient-care decisions or their input into patient-care decisions was often valued. The informants identified various aspects of their role or work environment that they thought needed to change for better patient care services, such as role autonomy, the nurse-physicians collaboration, and the amount of workload. In regards to their drive for work, the informants discussed a variety of internal and external motivation factors, including self-reliance, professional development, altruism, and expression of appreciation and encouragement from patients and families. Moreover, some of the narratives elucidate that a supportive working relation with colleagues and supervisors is another factor that affected the graduates' motivation in their work environment.

## Graduates' Role Preparedness: The Graduates' Perspectives

To inquire about the level of congruence between the graduates' preparation in the BScN program and the performance expectations of BScN nurses in the work environment, I asked all informants to reflect on their experiences and identify to what extent their professional education has prepared them for their work. I used a planned probe with this question if required: "What have you been able to apply or not been able to apply in what you have learned in your program?" In response, the informants reflected on various aspects of their performance that were required in their specific roles as staff nurses, team leaders, or nurse teachers. However, one informant reflected broadly and made a general comment: "My professional education prepared me in various ways whether it is for patient care in hospitals or community settings, or teaching. My academic background offered me a strong knowledge base, critical thinking, reasoning and decision-making, which is required everywhere."

As the informants reflected on the extent to which the BScN program had prepared them for their specific roles, they referred to various courses and the application of knowledge, skills, or behaviors acquired from those courses. I present their accounts under two categories: knowledge and skills, and professional attributes. For clarification, skills are not limited to psychomotor skills but inclusive of cognitive and affective aspects unless otherwise indicated.

### *Knowledge and Skills*

Many of the informants identified that although they had in depth theoretical knowledge, they had limitations in terms of their psychomotor skills. For example, Adil stated, "I think, most of the graduates have good knowledge, but they are not good in terms of skills, they are not so competent in hands-on skills. I feel they should have more clinical experience." Likewise, Anum reflected:

> The program equipped us with a basic knowledge of everything needed in patient care, and the ability to further develop it. I think every aspect of my knowledge that I acquired in the program is helping me in caring for patients. We have been taught different subjects in the program including health assessment, leadership and management, research, and advanced concepts in nursing. All of these courses prepared us for practice, like how to link information and see the interrelatedness, identify the probable outcome, deal with the people, and identify the outcomes of interventions. So I think, all of that knowledge was helpful. However, in terms of skills [psychomotor skills] there were some shortcomings, I mean the hands-on practice was not very good; we needed to polish our skills.

Diya's comments coincided with those of Anum:

> All the knowledge that I acquired at AKU-SON is helping us in the units but I think, it would have been better, if we had more knowledge about maternal and child care. I am learning it gradually…in general, I am able to apply all the knowledge gained through other courses like health assessment, adult health nursing, pediatric nursing, and maternal/child care to a certain extent. However, I think, certain aspects of the skills should be improved in the BScN program, such as cardiac-pulmonary resuscitation. Although we are BCLS certified, we had only done that on a dummy which is not sufficient.

Daud and Deeba reckoned that although most of the knowledge and skills required for patient care were acquired in the program, some of their abilities were developed or enhanced once they began to work as a staff nurse, such as the ability to work independently, time management in patient care, and communication with patients' families. Daud said:

> The school really prepares you well for knowledge and skills, I feel that I was very well prepared to work in a clinical setting because I learned to work as a staff

> nurse in a critical care area within two or three months with little supervision initially, and then I was independent. So naturally, most of what I was able to do in my work, I had learned it in my program, during my clinical rotations and all. However, one needs some experience to be able to work independently and to manage time efficiently.

Likewise, Deeba stated:

> I believe, we learned all the basics and ideal situations in our program, the basics of caring will never change, be that here or in any part of the entire world, though the circumstances may be different, so I think I was quite prepared for my basics skills as a nurse. I was able to apply all that I had learned, both knowledge and skills. We learned many things in our clinicals, such as psychomotor skills, including catheterization, nasogastric tube insertion, bed bath, policies and procedures in the hospitals, but my other skills, such as time management and communication with families, I really learned these as a staff nurse. Though we learned the general interpersonal skills and basics of communication in the program, its application in different situations were developed later. For example, how to communicate with the family members of a patient with a terminal condition, I have learned as a staff nurse, but the basics of interpersonal skills as what question to ask and what question not to ask, and how to articulate your question were part of our learning in the program. So I think most of what we learned in the program, I applied in my practice or I still apply in my present job.

One of the informants, a teacher, also described the application of her knowledge and skills into practice:

> Because the BScN program was comprised of both theory and practicum, it is helping me in my work. I have been involved in teaching various subjects, both nursing and non-nursing such as adult health nursing and pharmacology, and biostatistics. Everything that I learned helps, even the non-nursing knowledge like biostatistics. I use such concepts in my community health nursing course—like disease prevalence and incidence rates. So everything is related and put into use.

Unlike Deeba, Kiren believed that everything that she learned in her program could not be applied as it was taught in the program because there are differences in the way you learn things in the school of nursing and the way you actually do things in clinical practice. She explained her views with some specific examples:

> Somewhere you are able to apply what you have learned in your program, and somewhere it doesn't work because the theoretical situations are different than the practical situations. Some skills including problem-solving, decision-making, or conflict management that are taught in the leadership and management course, I use daily in my practice [as team leader] and it is very helpful. Similarly

> communication skills that we learned in theory, like how to deal with people who are rude to you or yell is applicable. I remember, what our teacher had said to us "don't argue when someone is yelling, let the person calm down, and take the person to a corner and then talk." Only yesterday, one of the patient attendants became very angry and started shouting at us, all the patients in that area became quiet. So the resident and I came out of that area instead of standing there and arguing back with the attendant, but we sent some senior members of our team to that area. So here the theory worked.
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> Sometimes what we have learned theoretically in our program is not possible to follow in practical situations, I mean doing things in depth and systematically. For example, we are taught how to insert an indwelling urinary catheter, which may sound like a very simple procedure. But it is very different when you have to insert a catheter in a patient with pulmonary edema, when the patient is very restless and almost in a sitting position, or if your patient is restrained and not cooperative. Though you want to maintain aseptic technique and follow all the steps of the procedure, it is difficult, you have to learn how to work with such a patient in real life and may not follow what you have been taught in the skills' lab during your program. Sometimes I feel that working in the skills' lab is like living in a fantasy world. We are taught to do things in an ideal way but things are very different in practical life.

Like Anum and Adil, Kiren affirmed that BScN graduates are not so good in their psychomotor skills; moreover, she identified some causes for this issue:

> Apparently, psychomotor skills is the key to clinical competence. Sometimes we are very quality conscious and don't allow our students to have the hands-on practice and then it becomes a problem when they join after graduation because they are expected to do it perfectly. One of the problems is that our hands-on practice during our winter and summer clinicals is limited. We are permitted to do certain things and not others. Even in electives we don't have much responsibility because we work with a preceptor. We need to be more involved. The other problem is that we are kind of kept away from the hands-on during the final year of the program. In that year, we are taught subjects like Psychiatric Nursing, Community Health, and Research which may be very useful for those who may work in a community setting, but not in the hospital where more psychomotor skills are expected of you. So there is a gap of one year after we have our clinicals in the hospital area. Though I may get to use some research skills or statistics, it is not used much in the hospital. It is the psychomotor skills that are needed in the hospital, especially when you join as a fresh graduate.

Unlike Kiren, Huma asserted that there is some mismatch between what the BScN program focuses on most and what is needed most in the clinical areas. To support her assertion, she explained:

> The BScN prepared me for many skills, such as patients' assessment, nursing care plans, critical care maps, documentation, reflections, paper writings, speaking for patient's rights, and conflicts management. We also learned different theories, but in reality these things don't help much. I think in the patient care areas, you need more of the psychomotor skills, such as cannulation, or medication, and time management. Medication is also a big issue in patient care, and I think in the BScN program, pharmacology should be strengthened, it should be considered as a major subject. In the clinical areas, you benefit from your psychomotor skills, but not from paper writing. Sometimes I feel that as a BScN graduate I am not more confident in my skills than a Diploma graduate. For assessment, usually, I do not have time to assess, but I do it rarely. For example I don't have time to auscultate for pulmonary edema. But I have to make medications like inotrops frequently, and then I have to look for the dilution file. If I had been taught more about drugs in the school, it would have been beneficial, I think we spend more time in school on skills that we use rarely in practice and vice versa.

Komal's views coincided with those of Huma:

> I think there is some gap between the school of nursing and the hospital nursing service. The school of nursing focuses on theory but limited practical experience, but in the hospital the head nurses or the CNT expect us to have good psychomotor or technical skills. For example, in our first year, we were certified for basic cardiac life support, but we were not taught how to run a code, cardio-pulmonary resuscitation, what is kept in the crash cart, how to assist in patient intubation, or how to use ambu bag/re-breathing bag accurately. The CNT expects you to know that because you are a BScN graduate. In the third year, we get some exposure to critical care areas, such as ICU or CCU or CICU, but it is not sufficient based on what is required from us. I think the faculty members are also not very competent in these skills. So I think, these things should be focused in the school of nursing....During our clinicals, we spent many hours on doing theoretical work, such as writing nursing care plans or developing concept maps, but we spent only five hours with the patients and learning about patients. Therefore, we learn more about patient symptoms from the books than in real patients.
>
> If you are working in a critical care unit or special care unit, you are in close contact with your patients and their physicians, then you can utilize your theory into practice, but if you work on the general units and have to look after the 10-15 patients, then you may be doing their medications, but you are not able to fully utilize your knowledge and skills. For example, we learn about physical examination in detail as the medical students are taught, but you can't apply such knowledge and skills unless you are working in a critical care area. Though you have the knowledge, you don't get the chance or you don't get the time to utilize your skills. So after five months or six months you forget everything that you learned in your program. We learn about so many theories in the school, such as those in the ACN [Advanced Concepts in Nursing], but you don't get the chance

> to work with your patients in that way because of the increased workload, even though you wish to work that way, but you are so tired and unable to do it.

However, Hirah presented a different view than Komal and Huma in regards to the usefulness of the ACN course and the development of concept maps:

> There are various qualities that I developed through my professional education. One is understanding and integration of theory into practice that we had learned in the ACN course through concept mapping or clinical care pathways. In concept mapping or pathways we learned how to relate the patient diagnosis with the patient's problems and present situation, like the lab values and physical assessment and understand how they are related. So it is helpful in patient care.

Kanwal also identified certain things that she learned in her program but was unable to practice due to lack of opportunity or time; however, unlike Huma, she was appreciative of her preparation in the program, including her knowledge in regards to pharmacology:

> Everything that we are doing on the unit is learned from the program. For example, my knowledge about diseases and medications, we know a lot about medicines, we are comfortable with doing medications—dilutions etcetera that we are suppose to do in practice. So this has really helped, but for skills, we didn't have more chance to practice skills; otherwise we are not doing something different, something new here.
>
> However, there are lots of things that we have done in the BScN Program that we are getting very little chance to do on the units, . . . such as teaching or research. We are unable to do anything of that kind, even to read articles or keep up-to-date with the literature. I have all of the privileges, I know I can go anywhere, search and read. I have all the resources but it is just that I don't have the time do that.

Considering Komal's comment about emergency drugs in a crash cart, I asked Kanwal about her experience in this regard. She responded:

> In our program, we have done all the inotropics, every medication in the crash cart, I mean we have done everything. It is just that you need to have more practice, you need to have more exposure to these things before you get comfortable with them or get them into your mind. So, it may require constant reviewing, otherwise you can easily forget it. Another factor could be that I had done my clinicals in CCU so maybe I had more chance of reviewing such things.

Contrary to Kanwal's views on the subject of pharmacology, Bilal pointed out that the BScN program needs some improvement in regards to pathophysiology and pharmacology:

> I think that our four year BScN program still has to improve in terms of content. Sometimes we felt that we were not imparted with sufficient knowledge in certain aspects, for example pathophysiology wasn't given that much importance and we just had a 3 credit pathophysiology course during our entire four years program. Most of the time in our nursing subjects, such as Adult Health Nursing in our 2nd year and 3rd year, we went into depth about certain disease process, for example patients with neurological problems, but we were not given details about each and every disease process. We were just given an overview of what sort of neurological problems were there and what sort of nursing care corresponded to that. And to give another example I have seen that nurses also lag behind when it comes to pharmacological content. If we are asked what sort of drugs have been given to the patients, what are their mode of actions, how they are excreted, metabolized, and stuff like that, what are the contraindications or interactions, I think it would help us. I feel nurses have drawbacks when it comes to pathophysiology and pharmacology.

Hamid revealed that he cannot practice most of what he learned in his BScN program due to limited availability of material resources as well as resistance from doctors:

> All the theories which I was taught in my BScNs program cannot be applied where I work now [another hospital]. In Pakistan, I think if a nurse has some knowledge of basic patient care, it is sufficient, you can't apply much even if you know a lot because of two reasons. One is the resistance from doctors [explained elsewhere] and the other is the limitation in material resources. For example, I was taught about various types of communicable diseases and the types of isolation needed in such patients, but there are no resources to practice this.

### *Professional Attributes*

Although most of the informants commented on the knowledge and skills they had acquired in the BScN program and the utilization or non-utilization of these skills in nursing practice, Atya, Hirah, and Aisha also alluded to some professional characteristics that one requires for continuous professional development. Atya asserted:

> The knowledge which we acquired from all the courses, we learned so many things in depth, and that in-depth knowledge is helping us. The program provided me with a foundation and now I have to further improve myself. The program helped us to develop professional characteristics and that is helping me. I would

> especially quote here the professional development course which I think is a very important course. It helped us to develop an understanding about the nursing profession, whatever I've learned in that course I try to apply it in my practice setting now.

Likewise, Hirah suggested:

> Communication skills, and all the teaching/learning which are very important, how to use the library, conduct a literature search, or make a presentation. In communication skills, you can differentiate non AKU-SON nurses from AKU-SON nurses based on their communication abilities. And also, we learned to work for longer hours in our professional education, that is at least 9 hours a day. Previously in our school/college [general education], we would attend classes for 3-4 hours at maximum, not more than that. So the professional education developed my habit of working hard and long hours, which you need as a professional.

Similarly, Aisha stated:

> I think the BScN has developed me a lot, especially those courses in our third or final year that developed our critical thinking, such as advanced concepts in nursing and professional development courses. We were taught various approaches to learning including literature search, and guided in self-directed learning, and that helps because I use the same approach with my students, while I am developing on what I have learned.

It is important to mention here that like Hirah and Aisha, a number of other informants also implicitly appreciated their ability for continuous self-directed learning.

### ***Summary***

In general, the graduates identified that in addition to theoretical knowledge and skills, including psychomotor skills, the program helped them to develop communication skills, learning skills, and the stamina to work long hours, which is important for professionals. Most of the graduates were able to use the knowledge and skills that they had acquired or developed in their program, but their perception of what has been most useful and what could have been most useful varied based on the informants area of work. For example, although a number of informants referred to the ACN course, some informants thought it helped them to develop their ability of critical thinking through the use of concept mapping whereas other informants thought that it could not be practiced in their clinical areas. However, there was consensus among many graduates that their psychomotor skills were not the best part of their preparation in the school or that these had reached a level that is needed in clinical nursing/patient care areas. Moreover, a number of informants indicated that the program offered them a foundation in nursing and it equipped them with certain learning abilities that they use for continuous development in their profession.

## Graduates' Strengths and Challenges

To obtain information about the strengths of BScN graduates and their applicability in the work environment, I asked all the informants, "What are your strengths as a degree nurse? And what are the challenges in using those strengths?" The informants identified various cognitive and interpersonal abilities as their strengths, including theoretical knowledge, problem-solving and decision-making, communication, and learning. Likewise, they alluded to some challenges in regards to applying their knowledge. Although some referred to themselves in identifying strengths, others made generalized comments. Their accounts are presented below in two categories: the graduates' strengths, and the challenges in using strengths.

### *Graduates' Strengths*

This category consists of the participants' comments about knowledge and associated abilities, communication and interpersonal skills, and teaching/learning and leadership abilities.

#### *Knowledge and Associated Abilities*

With some exceptions, most of the informants concurred that a strong knowledge base is their strength. They also referred to various cognitive and interpersonal abilities as their strengths. Furthermore, they reckoned that a sound knowledge was central to their other abilities, such as solving problems or communicating assertively.

Aisha said, "Our knowledge. We had a rigorous theory background, such as pathophysiology, and that helped to make a marked difference between us and the nondegree nurses." Deeba also thought, "It was knowledge since we had more of other courses than the diploma prepared nurses, so that was the main difference between us and them." Likewise, Komal affirmed that their theoretical preparations distinguished them from nondegree nurses:

> We were taught a lot and we have learned so much, so we are more knowledgeable. Plus we are self-directed. However, the main difference between a degree and nondegree nurse is the theory; otherwise all other things are in common.

A number of other participants not only acknowledged their theoretical background, but also related it to their other abilities, such as rational thinking and problem-solving. For example, Bahaar responded, "The theoretical background and rational thinking in patient care. I can always rationalize what I do for my patients, and this rationalization seems to be in the degree nurses"; whereas Atya stated:

> Knowledge and communication. As I mentioned earlier, knowledge helps us in everything, so if you have good knowledge about diseases and pathophysiology, you can identify and solve patients' problems. I think because of the knowledge I was able to become a good nurse. So my strength as a degree nurse is knowledge.

Similarly, Daud reflected on his theoretical background and his ability to make decisions in patient care:

> The most important strength was knowledge, the theoretical part, because we studied things in depth. So because of the knowledge, I could make decisions and manage things if necessary. I mean, if a patient's condition deteriorates, I could judge or interpret the situation and recognize things without always being dependent on the doctor or consultant, unlike the other nurses, who used to call doctors for simple matters. If a patient's temperature was high, they would try to access the doctor and ask, "Can I give a Calpol to the patient?" So I would use my judgment on the basis of my knowledge even if it was not expected of me, but being aware of the legal boundaries of my practice, I used to interact and collaborate with doctors to keep them informed about the patients' situations: "What is happening?" Let me give you an example of what I am trying to explain.
>
> Once, it was around one o'clock at night when another RN [nondegree] drew my attention to his patient's quickly dropping blood pressure. We were working in the same bay with different patients. When I looked at the patient's systolic pressure, it was in the eighties and continued to drop further, so there was no time to inform somebody and wait. So I started giving the patient a bolus hemaxel, plus I gave him one injection of epinephrine, and I asked somebody to inform the patient's doctor. Though according to policy we are not allowed to prescribe medicine, we are allowed to do things in a situation like that. So as a result of my actions, the patient's BP did not drop further. While I waited for the doctor, I began to look for what else was going on with the patient in regards to his medicines, and I noted that the patient was getting a sedative, and hypotension is one of it side effects, so I stopped that drug. So by the time the doctor came, I

> just informed him that this was happening and this is what I did. So there are certain situations where we need to take quick decision.

### *Communication and Interpersonal Skills*

A number of BScN graduates considered that self-confidence and communication also distinguishes them from nondegree nurses; many of them agreed that BScN graduates are assertive in their communication. However, they recognized that their assertiveness may influence their interpersonal relationships both negatively and positively. Anum stated, "Although, it may vary from person to person, the majority of BScN graduates are good in their theory, and they are good in their communication skills. Their language is good, and they are confident and assertive." Likewise, Kanwal said, "It is confidence in yourself in terms of knowledge. That is what distinguishes me from others." Similarly, Diya responded, "I am pretty confident in what I do. I focus on what I have to do, and I can take challenges." However, Arzu commented generally that BScNs are confident and assertive:

> An important quality of BScN graduates is that they are very confident and assertive. They don't polish [flatter] their supervisors more; they tell everything very assertively. So sometimes it facilitates things, but sometime it hinders also because too much assertiveness is not acceptable in our organization; it is not appreciated.

Based on Arzu's response, I asked her whether she has ever been penalized for being assertive:

> Nobody penalized me for it, but yes, they definitely said to me many times during their conversations—in between the lines the message has been, "You are assertive." Recently, I applied for higher education, so when I asked people for recommendations, out of the three referees; two wrote in their letters, "She is very assertive." I don't mind it and see it as a good quality, and in the recommendation letters also, that was mentioned as a strength. However, sometimes it is kind of shocking for management, a setback reaction: "Oh, what she said!" But they can't question it because what has been said is not wrong. And I am the type of person who doesn't keep grudges or hard feelings. Whatever I feel I just say bluntly regardless of who is there. Even with consultants, we speak assertively with them. Doctors habitually degrade nurses or make comments about them, but if they say something to us, I too, because I am vocal and confident, I also reply in a similar way, and then the matter is resolved there. We conclude the matter there by talking in the same way; we don't drag things out and impose that on our working relationship, nor do we let it affect our patient care. For example, if a doctor says

> anything to me because he is annoyed about something; I justify my point of view and respond then and there, and then the matter is concluded. But on the next shift we will work in the same manner as though nothing had happened. We will be helping each other as a team because we are team players. We conclude matters then and there and don't drag it out as "He said this to me, so now I should do this to him."

I also asked Arzu what makes BScN graduates confident:

> One thing is your background education; the other thing is your preparation in the program. Usually BScN graduates are intermediate, and most of them have a premedical background or preengineering background, so they have a good background education. Plus in our program there are so many activities that involve lots of interaction among the students, and between teachers and students. There are lots of interactive sessions like panel discussions, book reviews, and presentations; as a result, you become so much more vocal. Even if you don't want to, you do because you get marks for class participation, group participation, so your abilities increase. So maybe it makes you so much more vocal and confident that when you go to work as a bedside nurse, you are not quiet any more. If I talk about myself—when I came here I was a very quiet individual, but when I left here, I was much more vocal. So I think these are the reasons.

Aisha thought that professionalism in communication and interpersonal relationships is highly emphasized in their professional education, and hence it can be considered a strength of the degree nurses:

> We were expected to show a difference in interpersonal relationship skills with patients and physicians, and we were able to show that difference—the way we spoke to doctors and the way we spoke to our colleagues. When I began working as a staff nurse, I found my colleagues were not very professional in their interactions with patients, such as explaining to patients before they were taken for a procedure, but we were able to apply what we were taught, which made a difference. The patients used to give positive feedback that they enjoyed talking with us. And even with the doctors, there was a communication gap between nurses and doctors, there was a struggle between them because the doctors think they are superiors and nurses think they are not treated well or are made to feel inferior. So nurses were not very confident in communication with doctors. They always hesitated to speak to a consultant or a resident; they were not very confident about their own thinking and rationale. But we [BScN graduates] were not hesitant to speak to them [physicians]. We had a very good theoretical background, so we were not reluctant to question them. One of the important factors in communication is our English language skills. If you are unable to communicate in English, people may think you don't know anything, but we are able to communicate at a level, whether in English or Urdu, that makes a difference in the communication.

Atya also commented on her ability to maintain interpersonal relationships:

> I am very polite; people feel comfortable in talking to me. Because of the politeness, they are not reluctant to approach me and communicate openly. With patients, they usually praise me—"You talk very nicely"—so I feel that is one of my strengths.

I asked Atya, "Is it your personal strength, or did you acquire that in the program?" She replied, "My interpersonal skills are a mixture of both. I mean, to a certain extent, it is my personal strength, but also how my program has polished my skills."

### *Teaching/Learning and Leadership Abilities*

In addition to knowledge, some informants considered their leadership ability as a strength, whereas many viewed teaching/learning abilities as strengths that they had acquired in the program. In their view, such abilities have equipped them for continuous professional development. For example, Hirah reflected:

> BScN graduates are very competent and very interested in teaching students and staff. They are also given opportunities to precept or mentor other students. On the units, BScNs are very enthusiastic in teaching session compared to diplomas. They [diplomas] usually hesitate or they do not take an interest in teaching, but BScN graduates take advantage of this opportunity to educate staff very effectively.
>
> After I completed my professional education [BScN], I became very confident. In our professional education we had a routine of making presentations—presentations in a classroom and to large gatherings—and that was excellent. So now it helps me in my job as well as in my voluntary work in the community.

Deeba also reflected on her experience when she worked as a staff nurse at AKUH:

> We have the ability to teach, and we were asked to take the classes. The CNI [clinical nurse instructor] would give us a topic and ask us to prepare a talk and then present on that. In addition, there were some courses in which only the degree nurses were allowed to participate because these courses were originally designed for residents; hence, the complexity of the courses was at a high level, such as advanced cardiac life support courses.

Adil commented, "As a degree nurse, I think I have a strength to move ahead and make progress in my profession. I can easily go for higher education." Similarly, Aamna said, "I am able and open towards broad learning experiences." Huma affirmed, "Searching for knowledge or continuing education is also a strength of BScN nurses."

Kiren, Hirah, Diya, and Huma stated that BScNs also have leadership abilities. I asked Hirah and Huma what they meant by leadership abilities, and they alluded to various cognitive and technical abilities, such as problem-solving, decision-making, planning, organization, and coordination and allocation of staff.

Unlike the other informants, Bilal was not able to identify a strength that he thought was specific to BScN graduates. However, he hinted that his performance as a BScN graduate might potentially be different, but so far he has not been given an opportunity to demonstrate that:

> I would say that at this point in time both nondegree nurses and degree nurses have the same strengths, although we have a few courses that are different, such as leadership and management and professional development, but I have not been given the chance here to apply my knowledge and skills, and we still need time to come to that point in our career ladder to show the differences. At this point in time we are working at the same level.

### *Challenges in Using Strengths*

The informants identified various challenges in using their strengths, mainly a lack of acceptance or encouragement in the work environment and their workload. Because of these challenges, to a certain extent they found it difficult to actualize their potential, including applying their knowledge in making patient-care decisions, being motivated to advocate for patients, or developing personally.

#### *Lack of Acceptance and Encouragement*

Aamna, Bahaar, and Komal indicated that, being junior in the system, they had limited autonomy, and as a result, sometimes they felt restricted in applying their knowledge or exploring their potential for self-development. Komal reported:

> Sometimes we can apply our knowledge; sometimes we can't. Senior staff may not give you a chance to do what you can when you are new in your role. If you know something that should be changed because you think it will benefit the patient in some way, you just can't do it; you have to consult or ask your team leader to support you. However, sometimes they listen to you and respond to you positively, but sometimes they will say, "Let it be this way. Don't get into trouble; don't be bothered about this. Whatever the doctor is doing, whether right or wrong, don't interfere; let him do it." If the team leader is good and supports you and if the doctors are very good and they listen to you, it helps because you see a patient benefiting from your ideas. But if they don't listen to you, then at times I feel suppressed by my seniors.

Likewise, Aamna reflected:

> Sometimes I feel that juniors in the system are not accepted, but otherwise it is not bad. Asking your seniors to follow the channel [of command] could be challenging. However, I worked with that as well by changing my communication strategies and with some help from my supervisor.

Bahaar also affirmed that being junior could be a challenge in itself in the system:

> Being a very junior person in the system, sometimes when I am given an assignment or if I say "I want to do this," some people might say directly or indirectly, "She is very junior," and at times it is not encouraging. It reminds me of my experience of being junior in the hospital. At times, though, as a junior faculty I am appreciated as well, but at times they say, "You want to give this task to her; will she be able to do this? She is so junior." And, personally, I never refuse to do new things. I take it as an opportunity, because with more exposure, I will be able to learn more. For instance, I am very much interested in research and scholarly activities, but at times I am told, "You are not prepared at that level; you haven't done your master's." So this kind of hindrance is there.

Similarly, Diya reflected on her acceptance and adjustment in her initial days on the unit:

> The working environment, when you are new and if people are mean to you, there are adjustment problems, which I faced initially because people didn't know what kind of person I am. They didn't know me, and I didn't know what kind of mentality they had, so there were certain adjustment and acceptance problems.

Atya found that many of her colleagues, mainly nondegree nurses, resisted if she tried to share her learning:

> I have already mentioned that in the hospital nondegree nurses resisted me with a negative attitude. If I tried to clarify something, some colleagues were happy that I had good knowledge, but others thought that I was putting them down. So I am not sure if I should call it a challenge or not, but it affects you . . . . For example, once, there was a patient with Parkinson's disease, and the CCT who was assigned to that patient was asking the nurse who was responsible for this patient's medication about Parkinson's disease. The nurse, a diploma graduate, said something, but the CCT was not satisfied with her explanation [and responded], "No, no, I don't think so." Because I was standing by the counter, he involved me in the conversation, and when I shared my understanding of Parkinson's disease, the CCT said, "See! That is the correct definition. You are telling me wrong." So the nurse replied sarcastically, "*Hann in ko pata hai. Hum ko nahee aata*" ["Yes, they know it and we don't"], so that kind of feeling was very obvious.

I asked Atya if a diploma nurse had ever asked her for anything, and Atya replied: "Yes, there were a few people who would ask if they had a query, but the majority had this attitude; they would block us."

Kanwal's views coincided with those of Atya:

> It's just that when you use your knowledge, sometimes people find it difficult. I mean, it may be perceived that I am challenging the other person or trying to show that I am more clever. It's just that we [laughs] are so much in the habit of sharing things or saying things because you are encouraged to do it throughout your program. But here, sometimes people find it difficult.

Hirah suggested that applying knowledge may be difficult if it involves challenging a physician's decision in patient care because of the hierarchical relationship between physician and nurses. In addition, communication with physicians can also be an issue unless a nurse is competent and assertive:

> Application of knowledge can be difficult if it involves challenging a doctor's decision, because here you are faced with different people's egos; the relationship between doctors and nurses is not collegial, but hierarchical. However, if you are confident and competent, you can speak to them assertively, and then you don't have problems, so dealing with people is a challenge . . . . Sometimes the junior doctors like residents and interns don't listen to you or they don't respond to your call during the night shift, and you have to approach the consultant at his/her home because your patient is suffering. However, usually nondegree nurses are reluctant to speak to the consultants. But it shouldn't be like this. If you are competent and know what is going on, you should be confident and have the courage to speak to them.

Daud substantiated Hirah' views:

> The issue of power between nurses and doctors—for example, at times when you are trying to inform doctors or surgeons about their patients or give them some suggestion about what might be the reason for a change in the patient's condition, they ignore you or give an impression that you don't know or something like that. So this is not encouraging.

***Workload***

Some informants alluded to the workload and associated stress in the work environment. For example, Arzu commented:

> Your workload and stress in your work environment—you have a heavy workload, you are very stressed, your patient's haemodynamic is fluctuating, a

> consultant is standing at your head, the head nurse is checking your documentation and other things, so sometimes you lose your perspective on patient care.

Anum noted that nurses' questioning their workload or speaking for their rights is not appreciated:

> If you ask for your rights or are assertive about your rights, people think you are a troublemaker. For example, if you talk about your workload to the supervisors—"You want me to be a team leader besides giving direct care to ten patients. It is difficult or unfair"—then they will say, "You are getting too assertive." So basically fighting for your rights is not taken positively here.

Daud also acknowledged that assertiveness may pose problems in interpersonal relationships with others:

> I had so many problems with being assertive [chuckles]—problems with senior staff, with junior staff, and with surgeons. We learned so many things about [professional ethics]: that we should be punctual, we should be regular, and then we should be committed and all these things. But when I didn't find all of these things in other people, at times it annoyed me. I would tell people directly, and that was a big challenge for me during my work at AKUH. My assertiveness was a problem in my interpersonal relationships.

Huma identified various challenges, including workload and lack of support in the work environment:

> The challenges in using my strengths are lack of time, workload, lack of mentorship in my area of research, and freedom of expression. Sometimes I cannot speak for patients' rights because I am afraid that I will be scolded at the counter [public space], so sometimes I think that I am not very confident or a failure.

Unlike other informants, Deeba found no challenges in using her strengths because it was expected of her where she was working.

### *Summary*

In general, in addition to cognitive skills, the participants identified a strong theoretical background as a key strength of BScN graduates, as well as their abilities in teaching/learning and their continuous professional development. Some, but not all, of the graduates also viewed assertive communication as a strength. In terms of challenges, the participants cited their workload and resistance to or acceptance of them in the work environment. To a certain extent, the strengths and challenges identified in this section correspond with the graduates' narratives in previous sections, particularly their perceptions of being BScN graduates and their roles and responsibilities in the work environment.

## Application of Teaching and Research Knowledge

The BScN program at AKU-SON offers several specific courses, including teaching/learning principles, research, ethics and biostatistics that are thought to enhance the graduates' nursing practice. Therefore, I asked the informants some specific questions to inquire how far they were able to apply the knowledge and skills gained related to teaching and research activities in the work environment. Their responses indicated that they were able to utilize their teaching/learning knowledge far better than their knowledge about research. The actual questions along with of the informants' responses are described below under two categories: teaching and research.

### *Teaching*

In regards to teaching, I asked all the informants, except those who were working in a teaching position; "What kind of teaching activities are you involved with?" In response, all of them identified that they were involved in some of kind of teaching whether in a formal or informal way. Most of them commented on teaching patients and families. Many of them were involved in staff development or inservice teaching on their units, whereas some of them were participating in student teaching. Aisha pointed out that participation in teaching activities was an expectation from BScN graduates, and in fact they were able to fulfill the expectation quite well:

> When we graduated they expected us to conduct sessions because they knew that our theory background is good, therefore they always asked us or assigned us to conduct sessions for the unit staff. The management trusted our ability in teaching. So they always gave the teaching tasks to us. And as you see now, some BScN graduates have join the school after they had some experience in nursing services.

Likewise, Hirah shared:

> I had a chance to be a preceptor, which was a very good experience for me because one has to be very cautious when working as a role model for a student. I was also assigned to work for few months as a clinical nurse teacher where staff education was entirely my responsibility.

Most of the informants said that patient and families teaching is an ongoing process depending on the patient and family needs. However, Komal described that patient teaching is a required task of bedside nurses:

> Every month I conduct one inservice session. We are also supposed to teach the patients and their families, we have a patient education form, one for each patient that is kept in the bedside file, so it is compulsory to teach to the patient and fill that form. For students, I haven't been a preceptor, but I share literature with students when they come for their clinical rotation. I may also explain things to them if I have a free moment or if they ask me specific questions.

Concurrent with Komal's information about teaching patients, during my participant observation I found that a form entitled "Multidisciplinary patient education documentation tool" is included in each patients' file, so it can be used for patient or family education by nurses, doctors, and dietitians. Moreover, I noted that during the shift handover, the head nurse or clinical nurse teacher always check on whether that form is filled out or not. Completion of that form was also emphasized in staff meetings as reflected in one of my field notes:

> During the shift changeover, the team leader of the night shift and all the morning staff, including the HN and CNI were gathered in the nursing lounge. The HN and the CNI had some exchange of information with the staff. In preparation for the upcoming JCIA survey, the CNI and HN pointed out some of the weaknesses noted in the internal audit, such as the incongruency between patient diagnosis and rating on the pain assessment form. They urged the staff to pay attention in this regard, . . . as well as to completion of the patient education form. (PO, May 17, 2006)

Like Komal, Anum shared:

> Teaching patients and families has been part of my role as a staff nurse. I also have been involved in the staff education as our CNI sometimes assigns us a topic to search and then present to the staff. So we are used to this type of teaching. For students, usually when they have their clinical rotations in our unit, we have an opportunity to teach them too.

Huma alluded to the nature of patients teaching besides her involvement in the staff and students' teaching:

> In regards to patient teaching, it is an ongoing activity. I provide information to patients about their procedures and counsel them about diet; life style modification; and ways of expressing emotions if required. Teaching colleagues is also an ongoing activity for me, and I am also involved in the orientation of students and novice nurses. I participate in the completion of the CBO [competency based orientation] for new nurses in the unit.

Likewise, Bilal revealed:

> Any free time that we can get, I mean like we are sort of at this stage that we are mentoring the new nurses that are coming into our unit. In the past, we used to have a formal teaching schedule, where a person would be given a topic and he/she would present it to others, but now our patient census is so high that we do not have those sessions any more right now. So that's something that we find distressing. So now, it's more like self learning. Although our department arranges for a weekly grand round, nurses can go only if they are free. Teaching of patients and families is an ongoing process.

Kanwal, Daud, and Adil shared that they were not involved in teaching students but in teaching staff and patients. Kanwal said: "I am not involved in students' teaching, but sometimes in staff's teaching. For patient teaching, again I give them information in an informal way as the situation warrants, but I would like to do more than that." Similarly, Daud said that as a staff nurse, he had been involved in teaching of patients and families, and staff, but not students until he took his current position as a teacher; whereas Adil said:

> I have conducted some sessions for my unit staff on the assigned topics by our CNT, such as when we had a patient with VHF [Viral Hemorrhage Fever], I was asked to do a presentation on this topic. Some people were fearful that we have a VHF patient in the unit. So to deal with their fears or to address their concerns, we provided them the information about VHF. So teaching/learning is an ongoing activity in our unit.

Unlike others, Diya was not involved in staff teaching:

> I do patient teaching, but not staff teaching. Although, my CNT has told me that "you have the ability to take teaching classes for the colleagues and staff," I have not had a chance to do it yet, but I will do it in the near future. For students, I

> haven't been a preceptor, but I facilitate students when they want my guidance during clinical.

Hamid revealed:

> I didn't have any chance to conduct a session for the staff at AKUH, but in my present job, I have given some sessions to staff on the request of the unit management, so it's very helpful and I feel very proud of myself for that. I was also offered to join the school but I want to continue with my bedside practice to gain more experience.

### *Research*

To elicit information about research in their practice, I asked all the informants: "Have you been involved in any research activities since graduation; and if yes, tell me more about it?" Although many informants interpreted this question in a broader sense, some informants interpreted it as if I was asking them whether they have been conducting independent research. Hence, in the latter case, I probed them with "Do you keep yourself current with the literature? Or have you been required to search for recent information on a specific topic?

The informants' responses identified that in general about two-thirds of the informants were able to benefit from their knowledge and skills pertinent to research, mainly literature reviews on a specific topic as required in their work area or personally keeping up to date with literature. However, two of the informants were able to participate in a working project in their units which involved data collection, analysis and interpretation. Some informants reported that they are not able to keep themselves up to date with the literature because of time constraints related to rotating shifts and overtime work which is expected of them in the work place. In addition, few informants indicated other limitations, such as writing skills or in respect to participation in an existing research project, or finding a project that matches one's interest.

Among those who were able to benefit from their research skills, Huma stated:

> I am not involved in any research project, but since working here, I have searched the literature on various issues including infection control measures, attitude towards incident reporting, and professional attributes of health care professionals. Except the first topic, I have made presentations on the findings of these reviews to my colleagues.

I asked Huma about her purpose for a literature search on the first topic. She told me that it was to find out "how we do things in our unit in comparison to what is going on in other places like us." Like Huma, Bahaar also affirmed: "Yeah, literature review is something that I am very much in touch with; it is a continuous process because things keep changing." Komal also said, "I always try to keep myself up-to-date with the literature relevant to the kind of patients in our unit."

Though Bilal was able to keep himself current with the literature to a certain extent, he wished to be more involved in research activities:

> In my position, I have not been able to apply the knowledge related to research. Although, I do love to do some sort of research, specially in the area that I am working there are various aspect of care where research can be done by nurses and still I need time and time is something that I lack right now. We are so engulfed in performing our regular duties and stuff like that, so it becomes difficult.

I asked Bilal whether he reads any professional literature, to which he responded:

> That I do, but than I find that I am not reading as much as I should. I mean when it comes to reading research articles and stuff like that I am not reading as much as I should although I do read it and at times share it with the unit staff. Recently, I presented stuff on anticoagulant therapy. I do not know how they [nurse colleagues] found it, but that is something that I enjoyed.

A number of informants, especially those working in a critical care unit, shared that they were asked to search on specific topics pertinent to the staff needs and development of that particular unit. For example, Anum responded: "In our unit, we take turns to search and learn about new developments related to patient care management, and then present it to our colleagues." Kiren had similar response as Anum, she said, "we have a monthly schedule for teaching; we take turns to teach and learn, we have talks about policies, certain drugs, and patient management with certain conditions." I asked Kiren, what was the topic of her most recent contribution on that forum; to which she replied "A literature review on hyperbilirubinemia in neonates." In addition, Kiren also told me that she helped her head nurse to collect and analyze some data in regards to patients' admission and stay in their unit. This exercise was performed to identify the causes of delay in patients' discharge.

Unlike others, Aisha was involved in multiple research related activities because of her position as a nursing research assistant. Although Hirah sounded guilty that she was unable to make any use of her research knowledge, she has been involved in some research related activities:

> I am very bad in that area because four years have gone by since I graduated, but I haven't done anything in this area, though I am interested in doing research, but this is my very weak area. The only time that I used my research knowledge in our unit was comparing results of some surgical products from different brands, such as duoderm versus comfeel [names of the products] for bedsores or different types of ureostomy/ colostomy bags. It wasn't a formal research, but a small scale research activity, we kept and compared data on evaluation of these products to make a decision as to which product to continue with.

I asked Hirah, "Have you read any literature since you have graduated? She replied: "Yes, I participate in a research forum which is held every Friday morning in CHS [community health sciences]. We get articles from that forum, and I try to read that, I have developed a habit of reading those research articles.

Diya, Adil, and Kanwal acknowledged that they do not have time for research, even to conduct a literature review. Diya explained:

> I don't get such time to refresh or further my research interest that I had developed in my student life, but soon, *inshallah* [if it is God's will], I will pursue and do that. Recently, one of the faculty members was asking me about my past work, hopefully, I will soon approach her to further the work that I had initiated in my student life.

Likewise, Adil stated:

> No, I haven't been involved in any research activity. I read some general stuff, but I haven't worked or conducted a review on a specific topic. I go to the library rarely unless the CNT assigns me to find out something specific, because I don't have much time. Time is an issue!

Kanwal also identified that time is an issue for her: "With shift duties and double shifts, there is hardly any time left to think about research"

Daud, Aamna and Atya had been keeping themselves up-to-date with the literature as an expectation of their work, but they would like to participate in a research project and have been unable to do so for different reasons. For example, Aamna said:

> Yes, we had a research course in our BScN program but I didn't get much chance to be involved in any of the research projects up till now. I am interested in it but I didn't have a chance so far. I am very poor in scholarly writings, so I think [laughs] I need to improve on that first, like writing the literature review to get me enough confidence, so then I will try to participate in a research project.

Similarly Atya stated:

> I always think about research, but I have never been engaged in any kind of research project. In the service side I didn't get time, it was so tiring due to those shifting schedules that I never thought of research at all, now I do think about it. However, I am told that "you can't do something independently, but you can participate in a project because at the BScN level one is not expected to conduct their own studies. So I have to find something that matches my interest.

### *Summary*

Apparently nurses at AKUH have more opportunities in terms of teaching/ learning activities than in terms of research related activities. Therefore, the BScN graduates are able to utilize their teaching/ learning abilities far better than their knowledge about research. In general, the graduates' views coincided with supervisors' views in terms of BScN graduates' contribution in teaching/learning activities in the work environment. However, the BScN graduates contribution in terms of research related activities was almost not recognized by the informants in the supervisors' category.

## Perceptions of Nursing

To identify the BScN graduates' as well as their parents' perceptions of nursing and the BScN program, I asked all of the informants two questions: "What were your feelings about nursing before joining the program, at the completion of the program, and now?" and "Do you think your parents would have supported your decision to join the diploma program in nursing if the BScN program had not been available?" Their responses indicate that about one third of the informants were well aware of what it means to be a nurse because a close family member was a nurse, but the rest knew very little about nursing or the BScN program. Although some informants entered nursing because of their parents or peers influence, others were self-motivated. However, some of the latter had misconceptions about nursing. In the case of all of the Ismaili graduates, their parents supported or influenced their decision to join nursing rather than medicine out of respect for His Highness, Prince Karim Aga Khan, an advocate for the nursing profession. Prince Karim Aga Khan is the religious Imam or leader of the Ismaili Muslims and the founding chancellor of AKU. I present the informants' responses to the above questions in two categories: their perception of the profession before and after becoming nurses, and the influence of the BScN program on their parents' decision.

### *Perception of the Profession Before and After Becoming a Nurse*

Of the 16 informants, 5 had some understanding of nursing because one of their close family members was a nurse, such as a sibling or an aunt. Therefore, they made an informed decision to join nursing with or without the direct influence of their family members in nursing. These informants considered nursing an honourable profession that requires hard work. However, they varied in their attitudes towards nursing before and after becoming nurses. For example, Kanwal reported:

> I was very inspired by nursing as we have many nurses in our family. I used to like the hospital environment and everything about nurses, including their white dress, but when I went to college [after high school], I was more inclined to medicine. I thought I would become a doctor, but my aunt told me that there is a broad scope in nursing, so I joined nursing. Now I am very happy and content with what happened in my life. Everyone in my class, everyone who graduated with me, was very happy and proud. In my job, I have the feeling that this is a very tough job; an ordinary women cannot do this. I feel very special in a way that I am capable of doing nursing.

Anum indicated that although nursing was not really her passion, she was satisfied that she had become a nurse:

> I didn't have any desire to be a nurse, but two of my elder sisters are nurses. I joined the BScN program by chance with my college mates; I applied when they applied, thinking that if I get admission to the BScN, then I will do nursing. Had I not received admission to the BScN program, I would not have gone into the diploma program; . . . I would have become a fashion designer. However, I am happy that I have a BScN degree. I am satisfied in nursing.

Hamid and Kiren also had siblings in nursing. Although their siblings advised them not to join nursing because of the hardships involved in the profession, they decided to do so despite being aware of the difficulties of nursing. For example, Kiren explained:

> My elder sister was discouraging me from joining nursing. She thought all of us should not go into the same profession, plus she thought it requires hard work, it

> has many restrictions, and one doesn't have a social life in nursing. I felt that too in my second year while we were going crazy in our studies and while working as a nursing intern; I mean, in the initial months of my work as nurse. But I was aware of those challenges and willing to face them, and now I feel settled and proud.

Deeba was very inspired to become a nurse because one of her aunts is a nurse leader; however, after joining the program, she regretted her decision when her college mates influenced her to explore professions other than nursing:

> Before joining the program, I always wanted to be a nurse as I wanted to follow in the footsteps of my aunt. I never thought of anything else but nursing, which was a drawback, in hindsight. My friends used to say, "Don't limit your thinking; be open to searching for other options than nursing, so then you will be able to compare whether you want to do nursing or not." But I never ever thought of doing anything else. I wanted to join nursing from the very beginning, so that's why I took science in my secondary school, premedical in my intermediate, and then I went into nursing.
>
> During my program in nursing, my circle of friends was beyond nursing—I mean my college friends—and I saw them going in other directions, such as CA [chartered accounting], MBA, and some into computer science. Once or twice I attended the open house sessions at other universities with my friends, so then I realized that there are other things that I could have gone into. And during my first two years in the BScN, I realized that nursing was not my cup of tea. I really wanted to leave, but my cousin and everyone were saying, "After a BScN degree you can do a master's in another field, and it is not that you can't shift." I started looking for other opportunities that I may be able to pursue after this bachelor's degree, and I found out about the MBA, so I quit nursing after a year of working as a nurse.

I asked Deeba, "What made you think that nursing was not your cup of tea?" She responded:

> I think you have to have a passion to be a nurse. It is not a materialistic thing; that's what I believe. It is something that you are doing for others. Probably I wanted to do something for others, help others, and that's why I chose nursing. But for me that was not the right profession because I am not passionate enough to be a nurse. It requires caring from your heart! I can care, but not to that extent. As a person I was a lot more ambitious, and I thought I wouldn't be utilizing my maximum potential in nursing, plus I saw my friends going in other directions. I was ambitious too. I wanted to use my energy; I wanted to improve myself in a way to develop my potential or abilities and then to help others. But I realized that nursing was not improving myself, it wasn't utilizing me, so nursing wasn't the right path for me, and I decided to utilize my energy better somewhere else.

> Whoever is a nurse or whoever wants to be a nurse holds a special place in my heart. I still feel that way, but I am happy that I decided to move on because I was not the right match for nursing.

Unlike the above informants, Aamna, Bahaar, Hirah, and Huma had no close relatives in nursing, but they had developed a positive perception of nursing based on their Imam's advocacy of nursing and the increasing respect for nurses within Ismaili communities. Of these four informants, only Huma was encouraged by her mother to become a nurse, but the others had to convince their parents to be allowed to join nursing instead of medicine. Hirah said:

> In my family there was not a single person in nursing or the health care field, so, initially, I was very scared. I was afraid of dealing with wounds or blood. I was not confident to face this sort of thing. My parents wanted me to go into medicine, but in my community, because of His Highness, nursing is considered an excellent profession, so I was also very positive. In fact, I am very positive about nursing.

Similarly, Aamna stated:

> Before joining the BScN program, I attended an open house at AKU to find out about its programs. It was my dream to be a part of the AKU. I also had seen some nurses in my community; I wanted to be like them and wanted to be a nurse. I thought that it is a pride to be a nurse. With those strong feelings, I convinced my family. My respect for nursing was enhanced in the program. Before the program, I didn't know what it meant exactly to be a nurse, but now I know, and I am proud of my profession.

Among others, Huma also considered nursing an honourable profession. Moreover, she had also envisaged working in a good position with a sound income after the BScN program. However, her feelings about nursing varied after she began working as a nurse because she was not able to achieve what she expected in nursing:

> Before joining the program I thought of nursing as an honourable profession that can make a person financially independent. I wanted to help people, but also to be financially independent . . . . At the completion of my program I was very enthusiastic about nursing, but I am tired now. I earn only 10,000 rupees [< $200 CAD] per month. I am not working in a good position; perhaps the posts are for people who did the post-RN BScN program. Maybe I am not capable; I am only a staff nurse . . . . However, there is something in me that always motivates me to take interest and not to give up on my job. I do not want to be dependent on my husband; therefore, I do not want to leave my job and my freedom.

A number of participants, including Atya, Aisha, Bilal, Diya, and Komal, initially had negative perceptions of nursing. Although they were interested in becoming physicians, they joined nursing because either they could not get admission into a medical college or they were influenced by their parents to join nursing instead of medicine. Although at the time of the interview these informants sounded positive about their identity as nurses, it took them some time before they realized and accepted the value of nursing. Diya revealed:

> Before joining the program, in our high school we were told about Florence Nightingale and nursing. At that time I didn't want to become a nurse because I thought a nurse gives injections and that's it. Once my class teacher said to me, "Many people are going into this field, and why are you making such faces about nursing?" I said, "Because of the way I have seen nurses working; it's very pathetic." I used to think that anybody could become a nurse, so why should I become a nurse rather than something else? I was a top student in my school, and I used to say that I should not become a nurse. But when I went into college, the AKHS [Aga Khan Higher Secondary School], then my perceptions about nursing were changing because there were so many Ismaili girls who were planning to apply for nursing. I was reluctant though. I had even received admission to a medical college. Then my mom changed my views about nursing, and she said, "There are so many girls in our colony [neighbourhood]; you look at their status. You always say that nurses do not have good status and that anybody can become a nurse, but look at this lady; look at that lady. It is a very noble profession, and you should go into it." Then, despite all the negative perceptions, I got into nursing. In my orientation period in the program I was not convinced that I would continue with the nursing profession. But somehow time went by, and gradually I learned so many things that I am enjoying it now. [chuckles] I feel that my parents' choice of nursing was correct. The decision that they took for me was a hundred percent correct.

Like Diya, Aisha also had a very limited view of the scope of nursing until she had the opportunity to observe the role of nurses in a critical care unit:

> Before joining the program as well as during the program, especially the first year, I used to think that nurses have to look after only patients' basic care needs. I had no idea what nurses can do! But my thoughts have changed a lot since I did my elective in a critical care unit. I learned about the potential of a nurse when I saw the way the nurses worked there in collaboration with doctors. Nurses were more autonomous and respected in critical care units, so it changed my mind after completion of the BScN. Although nurses have a limited role and almost no respect in general units, they have a better role and more respect in critical care areas.

Atya's story revealed that neither she nor her parents were in favour of nursing, but preferred medicine. She wanted to become a journalist when she could not gain admission into a medical college; however, her parents did not support her decision. They allowed her to join the BScN program at AKU without realizing that their daughter would become a nurse:

> In my high school and college I never wanted to become a nurse. Never ever at that time [smiles upon reflection]! I had very negative feelings about nursing especially because of the way nurses were portrayed in the media. My passion was journalism; I wanted to become a journalist, but my father was very keen on medicine. He always used to say, "My daughter will become a doctor." So I was also interested in medicine. First I applied to medicine, but I couldn't pass the entry test. Then I wanted to go for journalism, but my father didn't allow me to go to Karachi University. When he didn't allow me to do journalism, I applied for nursing. It was like, "I tried to follow your wish, which wasn't successful, and now you are not allowing me to pursue my wish. Therefore I will do something that you don't like." Although my father had heard that a new program was being offered at AKU for the first time in Pakistan, he didn't know that it was a nursing program, so he allowed me to go to AKU.
>
> When I enrolled in nursing, on the very first day my thinking changed. In our first class in science, we had two faculty members. The way they were talking and teaching, the way they were encouraging students to participate was very different. It was a participatory approach that I had not seen before, so that changed my mind. However, when I started doing clinicals during the program, my feelings for nursing turned negative again. There are a few skills, such as handling a bedpan and everything, that I didn't like. If we don't have a clear understanding of why we do what we do, people like me would have an inferiority complex. Later when I realized that there is a reason for whatever I do, it helped me a lot and changed my thinking towards the profession.
>
> After the completion of my BScN, I was thinking that I am very fortunate to become a nurse because it changed my entire personality. I was a very shy, quiet, and hesitant person; and after doing my BScN, I turned into a confident person. People—in fact, my family—noticed this change in me. I was not at all assertive; I was very passive. Now I am totally a different person. This profession has given me honour in my home and in my community. I'm far ahead of my college mates, so I think I am the luckiest one. Although I joined nursing and rebelled against my parents, it ended in a different way . . . . My father is now proud of me. Whenever he talks to his friend, he says, "My daughter is an instructor, a professor at Aga Khan University." So he is very proud of me.

I asked Atya whether her father was also proud of her when she worked as a bedside nurse in the hospital, to which she replied:

> No. [sighs deeply] When I was working in the hospital, he had mixed feelings about nursing. He used to comment negatively about some of my tasks like bed making, but he used to feel happy about my abilities to help and guide people in their health care matters. He saw me working in the hospital about two or three times, and he was not that happy. I could see that in his facial expressions. He used to say, "What do you do—only make beds?" But now he is quite happy.

The above narratives clearly indicate that society including nurses' family members assign a negative value to the manual tasks that nurses do.

After becoming a nurse, Komal, like Diya and Atya, changed her perception of nursing from negative to somewhat positive, although at times she still questions the worth of her profession when she reflects on the role of nurses and the lack of appreciation for nurses in society:

> I didn't want to become a nurse, but a doctor. There was no nurse in my whole family. I had never seen what nurses do in a hospital except what I had seen in the TV programs or read in newspaper about them. So I really didn't know what a nurse was or what nursing was. I didn't want to join nursing, but my parents forced me into nursing. Until the second year of my BScN, I really didn't want to continue the program. I wanted to escape or withdraw from the program because I didn't feel that nursing was a good profession.
>
> After completing the BScN program, whatever I learned, it was certainly very amazing! Now if somebody asked me for advice about entering nursing, I would definitely advise them positively . . . . [However,] sometimes I have this feeling, Alas! If I were a doctor, I could be making decisions as they do or be respected as they usually are. Regardless of how much care you give to your patients as a nurse, they will usually say, "The doctor is very nice. The doctor has done everything for me. She taught me or looked after me whenever I needed a doctor"; or "The doctor always arrived on time" or whatever. But only a few patients would say, "The nurse is better than the doctor, and she has cared for me more than a doctor." So usually when you read the patients' comments [in the patient satisfaction survey], you feel disappointed because you think, although I have done so much for this patient, he or she appreciates the doctor more.

Like Komal, at times Bilal has mixed feelings about nursing:

> My feelings were almost the same as what people feel about nurses—that they are subordinates in the health care facility, that they are handmaidens and they are to follow the doctors' orders and stuff like that, that they do not have any clinical competence, clinical knowledge, or make decisions for themselves. That's what I thought of nursing before I became aware of what nursing is. However, once, one of the student counsellors in the hospital talked to me about the BScN program. I had no idea about what the BScN program was and that there was one at AKU, so

> I applied for BScN program as well as for the medical program. I was not accepted in the medical college, but I was in the BScN program, so I joined the School of Nursing.
>
> At the completion of the program I felt that I had accomplished something in my life, something worthwhile, but my own feelings about nursing vary sometimes. It all has to do with the work environment. As I said before, people still treat us as subordinates. They do not take our suggestions seriously. I mean, they have to think about it twice when it comes from a nurse. Had the same thing come from the medical side, more thought would be given to it; it would be given more weight. So we still face a lot of discrimination. These sort of things basically get me down or depress me because I wonder: "Did I make the right decision?" Stuff like that. Even in the community, people openly proclaim, "My son or my daughter is a doctor" or "My son is an MBA," but you do not see people saying, "My son or my daughter is a nurse," because the nursing profession is not being talked about in good terms.

I asked Bilal, "Are you or your parents reluctant to tell anyone else that you are a nurse?" He replied:

> No, they are proud of me. If people ask me, "What is your profession?" I say, "I am a nurse." They laugh at me: "Seriously, what profession?" I say, "Yes, I am a nurse." They say, "Are you crazy?" I say, "No." So sometimes it affects your confidence. When I tell people that I work at Aga Khan University, they say, "Oh, you must be a doctor." Why? Am I? I am a nurse. "You look like one." The people ask me, "Why did you join nursing? You know, I think you should have done your medicine. Why did you join nursing? Why did you come to this field?" So those sorts of questions, those sorts of comments make me think and make me doubt myself, but then I eventually get over it and I say, "I made the right decision."

I also asked Bilal, "Do people in your community make these comments about nursing because of your gender?" He responded:

> I think it is in general [pauses]—but I think it is more for men also, it is not acceptable for men to come into nursing. It's that old image of a nurse being a handmaiden; basically it is a female-dominated profession that I am fighting, making a stand for myself in a female-dominated profession. That is also another challenge for me, to be taken seriously as a guy in nursing . . . . I think the environment here [at AKUH] is self-explanatory. I mean, you do not find males in managerial positions on the hospital side. In fact, I can say that here there is hardly one head nurse, hardly one instructor or manager who is a guy, so guys do not have any sort of role model, someone who we can look up to and say, "Okay, I can become that person one day." All that we see are females, and then females are being placed with females, and this sort of discrimination automatically creeps into your mind.

Areeb, a secondary informant, had a similar story to Bilal's. In addition to his own lack of awareness about nursing before he came to nursing, Areeb regretted the lack of awareness and the worth of nursing in Pakistani society:

> I was totally unaware about the role of BScN nurse as what their responsibilities are or what they do exactly. I was expecting that I will take a round with doctors to check or examine patients and prescribe medicines. I was only thinking about disease process and treatment. I was not aware about nursing care or nursing actions. …When we started going for our clinicals, the environment there was totally new or strange for me. We were supposed to perform skills and procedures, such as shampooing a patient hair, sponge bath, perineal care, and catheterization of male and female patients, and all of that was very strange for me. Even once, I asked my teacher, "are we expected to catheterize a female patient in real practice?" She said, "if a female patient requires catheterization in emergency, and there is no female staff around, you will have to do it."
>
> I think the role of nurses is not clear to many people in our society. Even my family members don't understand the importance a nurse, they call me a *doctor*. "Do you know why? Because they feel ashamed to tell others that I am a nurse. What will you do of this nation? When will it change? It is difficult, but not impossible!

Like Bilal, Areeb, Aneel, Daud also entered nursing because of the BScN program without fully realizing what nursing involves:

> Honestly speaking, before joining I didn't know very much about nursing. I had just heard about the BScN program, that it was a very new program in Pakistan, so I didn't know anything about nursing. After I was in the program, I realized what nursing is, and at the beginning of my program it was a shock for me when, in our first year, we were taught do hygiene care, clean or bath patients. So before joining, I didn't know that I would have to do these things. Then, gradually, I got used to all these things. After I completed the program, I was excited that I would work and I would do things for patients that I couldn't do during my student life. But then there were some limitations. I was stressed in my job at AKUH. But after leaving AKUH, I feel pretty good because I am well appreciated and respected.

It is worth noting that Daud's story is similar to Atya's story as both of them entered nursing because of the BScN program. They had difficulties in accepting some of the nurses' tasks as bedside nurses. However, they felt content about being nurse teachers. To the contrary, although Aneel was also teaching in a nursing school at the time of this study, he revealed that he had no intention of being associated with nursing in the long run but wanted to become an environmentalist. Aneel, a secondary informant, enrolled for a BScN degree without understanding what it means to be a nurse: "I thought of nursing as what a doctor does." Moreover, during the program he resented the manual tasks of nurses, such as providing hygiene care. At the completion of the program, Aneel wanted to work only in a neonatal intensive care unit (NICU), and when his requested was not accommodated, he resigned from AKUH and joined a nursing school to teach non-nursing subjects that did not require experience in nursing. In addition, he began to work in a private medical clinic. I wondered why Aneel wanted to work only in NICU, and he told me that he did not like to wear a nurse's uniform and that this was one way to avoid it because all nurses wear scrub suits in NICU. As noted in Chapter Four, besides nurses, doctors and technicians also wear scrub suits; hence, a nurse's identity may not be so obvious as if he or she is wearing a white uniform. I asked Aneel why he did not like to wear a uniform, and he responded, "I don't know." However, considering his negative perception of nursing during the program, it is not difficult to understand that, perhaps subconsciously, Aneel had never liked being identified as a nurse.

Although Adil had a very positive perception of nursing after he became a nurse, he was very naïve about nursing before he joined the program:

> This is a very interesting question for me. Before I joined the BScN program, I had done a couple of diplomas related to health care, such as laboratory technician. During one of those diploma programs, we were required to work on units where I saw nurses mainly sitting on a chair and giving orders, because to them, you are a student and you are there to learn. So if a patient's attendant came to seek help about the patient's drip [IV infusion] or medication administration, nurses would instruct you, *"Baita Jaoo* [a polite way of commanding a person younger than you to go] and fix the patient's problem, and they would never accompany you, except for the first time when you are new and they need to teach you about how to manage things. And that's it; their task is completed. *Patient be farigh, aur nurse be farigh* ["Then things are over for the nurse as well as for the patient"—an amusing expression in Urdu]. So after watching and doing these things, I thought of doing nursing because it appeared a very relaxed job—nurses just sit and give orders! [chuckles] But when I joined here, it was another world! I have to work hard. However, I am not regretting what I did.
>
> I think nursing is a good profession. You can earn good money honourably if you do your work honestly and sincerely. It's a good job, and if you are doing that job with passion, then it is *Ibadat* [worship] because it is serving humanity. It gives you an inner satisfaction with what you do and what you earn, plus there are many opportunities for growth in this profession if you continue to upgrade your education—master's, PhD, or whatever. It is not like it used to be in the past, that once you completed a nursing diploma, that was good forever. Now

> you get a chance for further growth if you desire to grow. So, overall, it's a good profession.

### *Influence of the BScN Program on Parents' Decisions*

Of the 16 informants, only 6 indicated that their parents would not have supported their decision to join the diploma program in nursing if the BScN program had not been available, whereas the rest of the informants thought that perhaps it would not have made any difference had the BScN program not been available. For example, Aamna said, "They were not supportive of nursing at all, regardless of what the program was. For them, I was going into nursing; it was the profession that they saw as a problem." Adil pointed out, "Actually, people who are aware of nursing education may differentiate between the diploma and BScN, but others don't. Many people in our society don't know the difference between the programs, so it doesn't make much difference."

Aisha stated, "I had other options, such as going to medical school, but being Ismaili, we respect nursing. I would have joined the diploma [program] if the BScN was not available." Similarly, Deeba responded that "my parents would have supported me if I did a one-year certification course in nursing because they were so supportive of nursing." Bahaar pointed out that, although her parents were supportive of nursing, the other members of her family were not:

> Yes, they would have allowed me to take a diploma program too because they feel that nursing is a very good profession. When I told them that I would like to join nursing, they supported me a lot, even though the rest of my family members were thinking, "Why is she going into nursing?" because I had A+ grades in my high school. They thought I would go into medicine, like them. But I wanted to join nursing, and my parents supported my decision. I would have even joined the diploma program if I had not gained admission into the BScN program. On my application form for nursing I had ticked off both programs, not only the BScN program. However, I was selected for the BScN program because of my academic record.

Kanwal, Hamid, Anum, and Huma revealed that their parents would not have had any problem supporting their decision to enrol in nursing even in a diploma program because they had supported their siblings who had all entered a diploma program in nursing. However, as stated earlier, about one third of the informants had been supported for nursing by their parents because of the BScN program, like in the case of Bilal:

I don't think they would have allowed me or would have supported me. I guess the most important factor was that it was a degree offered by the AKU, which was a deciding factor. Nursing elsewhere—I don't think they would have supported me.

Diya responded similarly:

> Actually, I was selected for a medical college, but my parents wanted me to apply for a BScN. They told me, "These days our Imam is encouraging girls to go into the nursing profession, so you must try for the BScN—but only that, not a diploma." They also told me, "If you are not selected for the BScN, then you may go into medicine."

Likewise, Hirah replied:

> No, my parents wanted me to become a doctor. They wouldn't have allowed me to go into the diploma [program], but they allowed me to enrol in the BScN because they knew that, at least with a BScN degree, I would have a better chance of professional development.

### *Summary*

It was evident that many of the informants or their families viewed medicine as a more desirable profession than nursing. One of the reasons that nursing is considered an unfavourable profession in Pakistan is the lack of respect or appreciation for nurses' work, particularly the manual aspects of their work. However, the image of nursing has been changing in Ismaili communities because of His Highness, Prince Karim Aga Khan's advocacy for the profession of nursing. Although some informants were inspired to join nursing because they had a close family member in nursing or they knew a nurse in their community, a few were forced into nursing because of their parents' wishes. About one third of the participants would not have joined nursing if the BScN program had not been available.

The informants' accounts demonstrate that, in general, graduates who know about nurses' work and/or make a personal decision to join nursing are comparatively more content with their profession than are those who have not been exposed to nurses' work, roles, and responsibilities or those who entered nursing to fulfill their parent's wishes. Overall, two factors seemed to influence their satisfaction with nursing after they began to work as nurses: their awareness of and desire to work in the profession before they entered it, and appreciation for their role in the work environment and in the community.

## Perceptions of the BScN Program

To identify their perceptions of the BScN program, I asked two questions to all informants: "If you were to advise a young person who wants to join nursing, would you suggest that that person takes the BScN program?" and "Is the diploma program adequate for general nursing care?" The majority of the graduates, but not all, answered these questions affirmatively and supported their responses. I present their responses in two categories: advice on the BScN program and the adequacy of the diploma program.

### *Advice About the BScN Program*

The majority of the graduates responded affirmatively that they would advise others to join the BScN program because of its advantages, including the quality of patient care, a more extensive scope of practice, professional development opportunities within a short period of time, and its associated professional as well as financial advantages. However, a few of the graduates indicated that perhaps it would be better to begin nursing with a diploma, followed by a post-RN BScN degree, considering their personal experiences as BScN students and/or graduates within the context of AKUH. Moreover, they indicated that potential candidates for the BScN should make their decision with full awareness of the program and future prospects to avoid misconceptions and resulting disappointments in their career.

Hirah simply responded, "Yes, because it gives you better continuing education opportunities." Likewise, Adil replied, "Sure, I would, because you can have better opportunities within a shorter period of time with a BScN compared with a diploma in nursing." Aisha also explained that one can achieve maximum outcomes in a shorter period of time with a BScN degree because it offers a faster track to career growth:

> Yes, and I have advised others several times. One of my cousins is now a second-year BScN student. I feel a diploma prepared nurse does not have sufficient required knowledge these days. I think the BScN program has the potential to polish a person's qualities to the maximum, so I think the BScN is appropriate. It gives you more options after completing the degree. If you do a diploma first, you have to work for two years before you can apply for a degree; then you also need to see if you have enough money to go for a BScN; otherwise, you have to depend on the institution [AKUH]. If they have the capacity, they will send you for a BScN [post-RN BScN]; and, in return, you commit yourself to them for more services, two or four years depending on the type of support you had for your studies. I feel that, being a female, you have multiple tasks and don't have much time. You are pressured to get married, have children and rear them, and you have

> to support the family—husband and the in-laws. On the contrary, if you do your BScN first, it gives you fast-track career opportunities. You can go for a master's degree after one or two years of experience; after a master's degree, you may be hired at a good salary, . . . so you may achieve maximum outcomes in a shorter period of time instead of spending so many more years of your life.

Many of the graduates affirmed Aisha's views while reflecting on their personal experience as BScN graduates. For example, Komal replied:

> I would definitely advise them, if they want to do nursing, then they should do a BScN degree because it would polish their potentials or enhance their capabilities; it would help them to become a more mature person and a professional; it would increase their knowledge; it would help them in many aspects.

Likewise, Bahaar said:

> Yes, I would strongly suggest the BScN program because of the changes that I see in myself as a BScN nurse. The program helps you to maximise your abilities. Therefore, if a person is capable of gaining admission to the BScN program, I would advise it because it provides you with better opportunities in various regards.

Diya and Kanwal contended that a BScN degree would be more appropriate considering the anticipated advancement within the nursing profession:

> Definitely, I would suggest that they go for the BScN program; it has its own worth. When I was doing my bachelor's, I did not know that diploma nurses and BScN nurses would be viewed differently, but now I see this, and it gives me satisfaction that it was worth it. In the BScN program you get more time to become prepared as a nurse, and you get to study some additional subjects. I think the BScN program is demanded in this era as well. That's why I would suggest "Do a BScN; do a BScN!" (Diya)

> Yes, I would, because I think that the BScN degree is sort of equivalent to a medical degree. I have this perception that BScN graduates and doctors who are MBBS [Bachelor of Medicine, Bachelor of Surgery] are almost at the same level—maybe because of the treatment that we got in this institution [AKU]. We were treated equally with the medical students, and when we graduated, our dress or regalia was similar to theirs, and the degree that we got was similar. So it was very fascinating! The other thing is that these days nursing is advancing, and I've heard that soon the diploma program is going to be obsolete and a BScN will be required for entry to practice in nursing. So I advised most of my cousins and people in our neighbourhood, "If you want to do nursing, go for a BScN rather than a diploma." (Kanwal)

Kiren had a very pragmatic attitude towards both the programs, but she also preferred the BScN program:

> Yes, . . . there are many reasons. I personally feel happy and proud that I am a BScN. Being a BScN, you have more chances for growth in your profession. It is a faster way to get your degree. Two of my other sisters are nurses. They have a diploma, and I have a BScN, so I feel proud that I have studied more than they have. One of my sisters is doing a BScN after her diploma. So I suggest to others, "Go for a BScN if possible, but a diploma is not a bad option if you can't get admission to the BScN program."

Although Anum also favoured the BScN program, she suggested that it is important to know the pros and cons of both programs to make an informed decision:

> If I have a choice between the diploma and the BScN program, I would suggest the BScN program because it takes you only four years to get the degree, whereas if you plan to do a BScN [post-RN] after your diploma, it will take you a minimum of seven years to get your degree. Though there are pros and cons for this choice too. Sometimes a nurse with a post-RN BScN will have more opportunities than a nurse with a BScN has. But personally, I would advise the person who wants to join the profession to go for a BScN degree rather than a nursing diploma.

I asked Anum to explain her statement that post-RN BScNs will have more opportunities than BScNs, to which she replied:

> Basically, before you go for a post-RN BScN, you need to have a minimum of two years' experience, whereas in the BScN you need no prior work experience; you get work experience after the degree. What I have heard is that [pertinent to AKUH] usually after a post-RN BScN, you are hired in Grade 8 or 9 as an AHN or HN [assistant head nurse or head nurse], but as a BScN you are hired in Grade 7 as a staff nurse, and you may continue to work in the same grade for three or more than three years. So there are some differences between them.

Aamna also responded affirmatively, but pointed out that some people have misconceptions about the BScN program and that it is necessary to dispel them before entering the profession:

> Yes, I would suggest the BScN program, no doubt. If you go for a degree after a diploma, you get some years of experience between the programs, but you can also have experience after a BScN and save time. However, what I am hearing from the head nurses or nurses managers is that graduates of the BScN program are more interested in management posts, and everybody can't have a

> management post. So if this is the motive, you have to understand that, Okay, if I get the opportunity, I will take advantage of it; otherwise, I have to be involved in bedside nursing.

Deeba responded that a BScN degree would be appropriate for a person who desires a career in nursing, but not otherwise:

> It depends on the person who is really into nursing and who wants to make a career out of it, someone who is ambitious and who wants to go on with in her/his studies to do a bachelor's and probably do a master's. Then, yes, I would definitely advise that person to go into the BScN program. But a person who is not that ambitious and who wants to do a diploma and then work for a while and is probably not sure about the future, then probably a diploma is okay. Why waste a bachelor's seat?

Although Daud supported the BScN program because of its advantages over the diploma program, he expressed a concern about the retention of BScN-prepared nurses in clinical practice:

> Yes, I would suggest that the person takes the BScN program, because everyone wants to continue their education. It is easier and faster to do a master's or even go for doctoral education after a BScN. However, there is one drawback. After their BScN some people don't go to a clinical setting, and they do not practice nursing. Some of them even leave the profession. After their BScN they do a master's in another discipline and leave nursing, so that is a drawback.

I asked Daud whether anything could be done to retain BScN graduates at the bedside. He continued:

> As I have mentioned earlier, the graduates should be utilized effectively. The skills that we learned in our program are not used effectively. Only doing routine work as a bedside nurse is not sufficient. Just doing the shift duties day after day without reading a single article is tiring and boring because you are doing the same thing every day without any change.

Three of the graduates, Atya, Huma, and Bilal, were not confident about advising others to joining the BScN program or nursing because of their apparently disappointing experiences. Atya explained:

> I have to be very honest and open with you. I have a very different view about that. After doing my BScN, when I joined the service side, at that time I used to think, if I am doing the same work as diploma nurses, why did I do the BScN? I should have done a diploma. And another thing is that during our program we had

> some combined classes with post-RN BScN students who were very vocal and mature; they had the ability to approach things differently than us. So I was very impressed by the post-RN BScN students because of their vision and approach to learning, and at that time I used to think, I should have done a diploma first. I should have had some experience before doing the degree so I would have been able to integrate my experience with learning; I would have been able to understand things better.

Like Atya, Huma also suggested that it would be better to begin nursing with a diploma followed by a degree:

> I would advise a young person who wants to join nursing to go into the diploma program first and then do a post-RN BScN. In this way, during your post-RN BScN studies, you can explore and learn more about some of the work issues or knowledge gaps that you became aware of from your experience, and you may find some effective solutions. Some of the knowledge that you gain during your BScN program is useless when you are working as a staff nurse, so it is better to initially learn and focus on the clinical skills.

Bilal thought, "It is a difficult question." I asked him why, and he replied:

> When I was a student I used to encourage a lot of people: "This is a new field, a new program with a better scope than medicine. It has great opportunities abroad; you will be recognized all over," stuff like that. However, after being in the field as a professional, the way nurses are actually treated, their pay scale and stuff like that, it makes me think, "Okay, if you want to come to nursing for a BScN, you should know what will happen to you after you complete the program." I would not like a person to point a finger at me for encouraging him to join the field and then become disappointed. So now I do not openly encourage people any more; I give them the pros and cons and explain what I have gone through and then let them decide. I tell them, "As students, you live a very sheltered life, and you have no idea what it is like to work in the real world."

### *Adequacy of the Diploma Program*

With regard to the adequacy of the diploma program, all of the graduates except four responded affirmatively. However, most of them indicated their preference for the BScN program. They explained that although the diploma program prepares nurses adequately for basic patient care skills—mainly psychomotor and interpersonal—the BScN program prepares nurses for a broader scope of practice in addition to basic patient care skills. A few of the graduates pointed out that although preparing nurses professionally in a specific program such as the BScN might enhance their competence, their actual performance varies because of their individual capabilities. Some of the participants considered the diploma program inadequate, and some expressed their preference for the BScN program because of its advantages over the diploma program. They argued that a BScN degree for entry to practice is more appropriate considering the fast-changing needs of society and the need to enhance the professional image of nurses and nursing as a profession.

Hirah responded affirmatively that the diploma program is adequate for bedside nursing. Likewise, Bilal replied, "Of course it is. Hospitals have been working with diploma graduates for the past twenty years." Similarly, Kanwal said, "I think for general nursing, yes, it is adequate. The BScN teaches you additional things such as teaching and research subjects. So being a BScN graduate, you learn a few other things besides general nursing care." Deeba affirmed that although the BScN program sharpens critical thinking, the diploma program prepares nurses with adequate psychomotor and interpersonal skills for general nursing:

> I do feel that the diploma is adequate because for general nursing care you need psychomotor skills and the basics of nursing practice. So I think the diploma program is adequate for general nursing, but, of course, a degree is better. You get to learn more in terms of knowledge—not in terms of psychomotor skills, but in terms of knowledge a BScN is way higher than a diploma, but a diploma is sufficient. . . . If you do a bachelor's degree, it is good; if you do a master's in nursing, it is excellent; if you do a PhD in nursing and work for any cause of nursing, it's outstanding. But at a very basic level, a diploma is sufficient. . . . If we think of psychomotor skills and interpersonal skills, a diploma is sufficient, but not critical thinking and problem-solving because critical thinking depends on your knowledge as well as many things in your environment: How do you use your mind? How do you come up with the solution? and so on.

Aamna's views corroborated those of Deeba and Kanwal. Aamna was cognisant of experiential learning, and she also referred to individual differences in addition to the differences in the programs:

> Yes, if you work as a bedside nurse, diploma graduates are provided sufficient knowledge, but how individuals perform may vary. And working with diploma graduates on the unit, I have learned a lot from them, so they are adequately prepared for patient care . . . . But BScN nurses have additional preparation. They take more courses that teach them critical-thinking and leadership skills, which can help in dealing with clients. And if you are working in a management or some kind of supervisory position, this preparation can again help you a lot. But I must

> mention that diploma nurses can also be good supervisors because they may have learned things through their experience.

From [illegible] perspective too, a nurse's performance depends on her/his personal abilities; the program helps only to a certain extent:

> It is adequate; why not? Some people can do a good job despite certain limitations. We have some nurses who have done a BScN, but they don't actualize their potential; they don't present the quality or standards that a BScN nurse should. And there are some diploma-prepared nurses who are really very sharp and who can tackle things, and they can do things very well. The BScN program offers you some learning that you don't get in the diploma program. Definitely the program helps, but the individual's abilities also count.

Like many other graduates, Daud did not question the adequacy of the diploma program for patient care, but favoured the BScN program over the diploma because it ensures a broader professional scope and better monetary prospects:

> Yes, the diploma program is adequate. Many diploma nurses are competent in the clinical setting, and they are very good at patient care. Basically, both programs, the BScN and the diploma, are planned for general nursing or clinical nursing. But with the diploma program you are limited to bedside nursing, and with the BScN you have more options; for example, you can work as a nurse teacher on the unit or in a school, or as a research assistant. Plus you may earn a good salary if you get a good position.

Although Anum seemed to consider the diploma program adequate, she was apparently not sure, as she implied in the following statement:

> What I think is that some of the courses, such as the health assessment course that is taught in the BScN program, should also be included in the diploma program. I think every bedside nurse needs it, so it is important. The diploma program is adequate too, but some areas in the program could be enhanced.

Huma shared that most of the times, she could not apply some of her abilities, other than the psychomotor skills that she had learned in the BScN program, to her work as a staff nurse; hence, she expressed with some disappoint that the diploma program is adequate for bedside nursing:

> Yes, I think it is adequate for general nursing care because no one cares about patients' rights and concerns or makes use of writings skills that we learn by writing a lot of papers during the BScN program. In my opinion, other health

> members do not want nurses to talk; they only want patient basic care. In other words, all the skills [psychomotor] should be performed on time, and physicians' orders should be carried out in a timely manner. So I think diploma nurses are adequate for this purpose.

Bahaar agreed that the diploma program is adequate for entry to practice in nursing, but she considered the BScN program more appropriate in light of the changing needs of society and the implications for nursing care:

> Yes, for general nursing care it is adequate. But again, at some point it will be necessary to upgrade your knowledge. Therefore it is better to go for a BScN because of its advantages. One advantage is that you can get the degree in a comparatively short period of time, and a second advantage is that you begin your clinical practice with better knowledge, which is important because patient care is getting more challenging as our society is developing.

Kiren's comments affirmed Bahaar' views:

> Yes, but a BScN is demanded at this time. People consult you because you have additional knowledge compared to diploma nurses. The ways of thinking are also changing. Professionals talk about integrating research into their practice, so these things require a BScN. If we need to see improvement in our profession, then we should be thinking a step ahead.

Like Bahaar and Kiren, Adil thought that the diploma program is "okay," but he emphasized the importance of a BScN degree for entry to practice in nursing:

> It's okay, but if we want to upgrade the entry-level education, we should go for a BScN. If we want to improve the image of nursing in the future and the growth of nursing as a profession, we need better-educated people or people who have a good basic education. One may upgrade education on an ongoing basis, but it is not the same as having a good basic education before entering the profession. For example, many diploma-prepared nurses today entered nursing with matric [a secondary school certificate]. They are professionals, they have professional knowledge, but in terms of their basic education, they don't have any degree or college education; they don't have any college- or university-level exposure, so these nurses have limited abilities.

Four graduates—Atya, Aisha, Hamid, and Komal—contended that diploma preparation is inadequate for general nursing. Hamid replied, "No, I don't think that a diploma in nursing is sufficient these days, even for general nursing care." Aisha explained that, to fulfill the expectations of patients as well as physicians, nurses should have at least a BScN degree to begin their career:

> Considering the growing literacy level and people's access to information these days, nurses have to be prepared at a better level. Now our patients are very knowledgeable or their level of awareness has increased, plus disease patterns have changed, so I feel nurses should be prepared at least at the BScN level to fulfill those patients' expectations. When patients come to a hospital, they know about their disease and treatment options, so you have to be knowledgeable to interact with them; otherwise it will be difficult to deal with them. In addition, people usually come to the hospital with more than one disease—not one or two, but at times with multiple complications, so to deal with such patients, you need to have sufficient professional knowledge and skills to care for them . . . . And also new roles have been introduced for nurses, such as case manager, and they are expected to work closely with physicians. So you need good knowledge and interpersonal skills, and the BScN program prepares you better.

Komal's and Atya's views substantiated Aisha's claim:

> No, because in the diploma program you learn only the basics of nursing without any in-depth knowledge. In the BScN program you are taught to reason what you do as you study things in depth and try to find the relationship among different things in patient care. Plus in the BScN you get the opportunity to do a senior elective, and you get the opportunity to have professional development courses. So once you are on the unit, you can work more maturely and professionally with regard to your relationships with colleagues, both doctors and nurses . . . . Having professional relationship means that you maintain a balance, you know your limits, you know your abilities, and you maintain a professional working relationship with your colleagues. [To the contrary,] an unprofessional relationship is working with doctors or with staff on the counter and joking and laughing while patients and their attendants are watching you and get a bad impression. They may begin to think, "Is this a professional nurse? Is this an AKU nurse?" The way you dress, talk, or associate with others make an impression. (Komal)
>
> No, I feel that if we have thorough knowledge, then we can provide better care. In the diploma program you are taught about different diseases processes and all, but it is not as in-depth as it is in the BScN. So that's why I think that this is not enough. Plus time is another issue in the diploma program: How much can you teach in three years? (Atya)

### ***Summary***

Overall, the graduates' accounts reflected a very positive perception of the BScN program. With some exceptions, they were all willing to advise others to take the program. They all identified advantages of the BScN program, including its potential to maximize nurses' personal capabilities, its ability to offer a faster route to professional development for nurses, and the future prospect of professional recognition and financial status for BScN nurses. Most of the graduates, but not all, considered the diploma program adequate to prepare nurses for general nursing care or bedside nursing; however, they preferred the BScN program over the diploma because of the above-mentioned advantages. They contended that a BScN degree for entry to practice is more appropriate to address the fast-changing needs of society as well as to enhance the professional image of nurses and nursing as a profession.

## Future Aspirations of the BScN Graduates

To elicit information about the graduates' future plans and continuity in the nursing profession, I asked all the informants, "Where would you like to see yourself five years from now? If you had an opportunity to change your profession, what would you choose? Why?" Almost all of them responded that they were interested in upgrading their education in Pakistan or abroad. However, none indicated a desire to leave the profession, except for one, who had already left the profession and would never consider rejoining the nursing profession. Details of the informants' responses are presented below in two categories: future plans and views on changing their profession.

### ***Future Plans***

Although most of the graduates indicated their interest in professional growth and development through upgrading their knowledge and skills, some of them appeared clearer than others about their future plans. Adil was the only graduate who said that he had no plans when I asked him where he would like to see himself five years from now: "It's a difficult question for me because I don't have a plan that I will do these things so that I will be there or I will be having this." However, all other informants stated their ambitions.

Inarah and Atya were enrolled in a part-time Master of Business Administration Program (MBA); hence their first priority, in addition to their full-time job in nursing, was to complete the program. Atya reported:

> I've enrolled in the MBA program. I wish to continue that program besides my current position at AKU. I would like to see myself as very competent in teaching

> as well as in administration. I would continue to serve my institution and the community.

Likewise, Inarah told me:

> I worked for six months, and then I started my MBA. I did one semester and I took a break, and then resumed. I wanted to do something that would really boost me or something that would make me empowered and give me some autonomy to work, and I verbalized this plan with my parents, who supported me. Now I am about to complete that.

Aamna replied that in five years she will be a "MScN student [laughs], not earlier than this. It will take some time because of family commitments: four or five years approximately." Anum responded, "I may have my master's done or be a master's student, and then I will go for a PhD. But certainly I will go for further studies." Bilal's plans were more concrete: "Five years from now I see myself with a master's degree in my hand."

Bahaar asserted, "I would like to see myself more skillful faculty member with a solid educational background, and if I have the opportunity, I will go for a master's; otherwise, at least some short courses to advance my knowledge." Komal wanted "to become a nurse practitioner in oncology. I want to do something for the oncology patients"; and Hirah stated, "I have a plan to complete my master's and continue in a teaching cadre." It is important to mention that nearly half of the informants wanted to pursue a teaching track.

Some informants revealed that they desired to go abroad as well as upgrade their education. For example, Diya responded:

> Imagination! [laughs] Five years from now, I am not a person who will stay static as a staff nurse. I'll definitely grow in terms of my studies and personally, so within five years I would see myself much better than now. I should complete my master's at least [appears to be thinking], and I will definitely serve here in Pakistan, even if I get further education from abroad.

Huma reported that she was required to make some changes in her initial career plans because of her engagement and upcoming marriage plans:

> Before my engagement I wanted to go abroad for a master's, and I wanted to be in a management post. But at this moment I am not sure. I still want to do a master's

> in five years and be an independent working woman, but I may not go for a management position because I think I will not be able to manage too many responsibilities; I mean, marital life plus work.

In response to my question, Kiren said, "Five years seems too long!" I replied, "Let's reduce it to three years," and Kiren continued, "I wanted to apply for a master's this year, but because of different problems, I couldn't. So I am thinking about a master's next year, if possible; otherwise, I will see what happens." I asked, "So you have no plans to go abroad?" She replied, "I have that pressure too. My sister is in Canada, but I need time to prepare for all the exams. So I will take some time to prepare; whatever is possible."

Hamid and Kanwal indicated that their priority was to deal with their financial issues first; however, they also planned [illegible] upgrade their education. Hamid stated:

> I am planning to go abroad after at least one year of experience as a staff nurse. I completed my degree on some financial aid plus a loan from AKU. It is very difficult for me in Pakistan to have money for my family members and also pay the loan. So that is why I am just working to get experience and go abroad. Besides going abroad, I have the ambition to enter a master's program.

It is worth noting that the above excerpt substantiates some of the supervisors' views about one reason of turnover of BScN nurses at AKUH.

Like Hamid, Kanwal responded:

> Five years from now I see myself working abroad, probably married. And I also wish to do my master's. I don't know; it all depends on God's will, but I really wish to do my master's, so that's what I have in my mind—further education and going abroad . . . . I haven't applied anywhere yet because I want to do one year in the unit where I am working right now just to be confident in my skills, and then I would think of working in the same institution, but on another unit. And then I will apply for abroad.

I asked Kanwal, "Why would you like to go abroad?"

> Basically, it is because of the pay; they pay you well abroad. My parents are quite old. Father is quite sick and retired, so I need to support my family. We have financial problems; I think it would be much easier to resolve these if I go abroad. I might come back after this problem is addressed because I think doing a master's at AKU would be much convenient for me.

I then asked her whether she would reconsider her plan to go abroad if the administration here decided to double nurses' salary, to which she replied, "It might stop me."

However, Aisha revealed that she was about to complete the migration process to the USA:

> I have no specific plans, but I certainly see myself studying. My aim is to do a master's and then a PhD. I will be working in a hospital as well as a faculty, as a joint faculty, because I enjoy patients besides teaching students. But my first priority is my education. I will complete my education.

### *Views on Changing Their Profession*

Most of the informants, including Adil, Hamid, Diya, Kiren, Anum, and Bahaar, had no plans to change their profession if they were given the opportunity to do so. For example, Hirah said, "No, I don't want to change my profession"; and Atya commented, "Now? I don't think that I have to change my profession. I like it now." Huma declared, "No, I will grow in this field only." Likewise, Adil also noted that "in the future I would try to further enhance my skills and grow in the profession. I will not change the profession"; and Aamna responded, "I don't want to change. Since I have joined nursing, I have become so dedicated to nursing that even thinking about something else would be difficult for me."

A number of informants indicated that they might do something different from what they were doing now, but it would be certainly within the profession of nursing. For example, Aisha indicated, "I might work as a nurse practitioner, but I don't want to change my profession." Similarly, Inarah said, "Actually, I won't change my profession. I will become a nursing recruiter. After completing my MBA, I will go for my master's in HR [human resources] so that I can specifically work in nursing recruitment." Bilal concurred:

> I would not like to change my profession either. I would like to build on it. I will go for a master's degree or go into public health and build on my nursing skills, but I would still retain my original nursing identity. A nurse is a nurse; she/he cannot be replaced. Nurses are an integral part of the health care environment.

### *Summary*

In general, almost all of the informants expressed their desire for professional growth and development, and some also reflected on their plans for their personal lives. Their ambitions for higher education are evident, which coincides with the supervisors' views that BScN graduates are very keen on upgrading their professional education. Although all of the informants wished to continue in their profession, they would not necessarily continue to work at AKU, but might go abroad to seek better opportunities. On one hand, the above information corroborates the supervisors' views that many of the BScN graduates wish to work abroad; on the other hand, it refutes the prevailing perception at AKU that BScN graduates are not interested in the nursing profession but that they use the BScN as a steppingstone into other fields of work.

## Suggestions for the BScN Program Improvement

To obtain the informants' suggestions for improvements to the BScN program or its curriculum, I asked them two questions: "What suggestions do you have for the four-year BScN program in the future?" and "What changes would you recommend to the curriculum for the four-year BScN program?" One of the graduates, Anum, responded that "the curriculum is good. It is very comprehensive, and there is no need to add or delete anything." The rest of the graduates identified various areas for improvement relevant to the curriculum content and/or delivery, and I present their narratives in two categories: content of the curriculum and delivery of the curriculum.

### *Content of the Curriculum*

This category comprises the informants' responses pertinent to the gaps in the content of the curriculum as well as suggestions for improvement, either in general or to specific areas of the curriculum.

Bahaar lamented that some content that is relevant to the context of Pakistan is missing in the curriculum; hence, she suggested a curriculum review to ensure its relevance to the context of the country:

> There are some health conditions or diseases that are relevant to our context, but they are missing in the curriculum. Because usually we depend on foreign books, most of our curriculum is developed from a foreign perspective. I feel that our curriculum should be reviewed within the context of Pakistan and its population's needs; I mean, the particular setting in which we are living. There are many

> conditions or diseases that we frequently see in our clinical areas, but they are not included in our curriculum, and that needs to be integrated. For example, post-polio syndrome is common. Parents don't know how to care for such children, and some of these children are given to Edhi [a well-known welfare trust in Pakistan], or at times they become beggars. Though we address polio in our curriculum, we are not paying attention to post-polio syndrome.

Huma pointed out that the problem-based learning (PBL) tutorials in the program were based on hypothetical situations. She contended that it would be more effective in enhancing students' critical thinking if real patient scenarios were used instead of hypothetical situations:

> To enhance critical thinking in PBL, we should select a real patient during our clinicals instead of discussing hypothetical patients. We should have in-depth discussion about real patients—assess and identify interventions, implement those interventions, and evaluate their effectiveness. In this way every student will be able to participate in patient care and see the effectiveness of those interventions.

Deeba felt that, although the curriculum is good, it focuses merely on health and diseases, and she recommended integration of information other than health or nursing into the BScN curriculum to broaden nurses' views beyond health care perspectives:

> A lot of times I feel that nursing is too much on one track like medicine, focusing on diseases and health. A person in nursing most of the time doesn't know what is going on in this half of this world, which I think is a drawback of nursing—whether it is only our curriculum [at AKU-SON], or maybe it is a worldwide issue in nursing that your mind is geared on one side. So I have a general issue with the curriculum of nursing, be it the BScN or diploma curriculum. It is just one sided; people are not open to knowledge from different sectors other than the health care industry. It would have been beneficial if either a course or seminars were offered to make nursing students aware of other things in life. Yes, I understand that you have chosen a career—nursing—but then you must know what else there is in the world. So give them information about other things, such as the transport industry, the manufacturing industry, and finance and economics in the country so that nurses can be a part of the global world instead of just health, health, and health . . . . Either one should participate in certain workshops that are offered by other schools, such as in the school of leadership, which offers many such workshops, or AKU-SON could work with them to organize a course or special seminars. One may request experienced professionals in other industries to conduct a workshop or seminar for AKU-SON on a Saturday. This might not be mandatory for all students, but for those who wish to broaden their knowledge and thinking. I think that is important, because in our world you can't live with a one-track mind.

Bilal emphasized the need for improving nurses' clinical knowledge. Moreover, he suggested that it would be more appropriate and beneficial to seek the views of the first cohort of BScN graduates to identify curriculum gaps:

> I would like to see the nurses in the four-year BScN curriculum have more clinical knowledge. In regard to recommending changes in the curriculum, I would say that you need to get the graduates of the first BScN program in and review what's happening and ask them to make recommendations. They are the best people; they are the pioneers. They have also been through the programs and will be able to make suggestions on how they feel about being nurses from the four-year BScN program, what they liked, what they didn't like, what could be done to improve their knowledge and skills level.

I asked Bilal to elaborate on clinical knowledge:

> For example, we do not spend that much time in critical care areas. It is just a small rotation period, and then, as a result, the person does not have that much time to retain or grasp the concepts. The only time that you can grasp those specific concepts is when you work there on your summer clinical placement, but what if you don't get there? Otherwise, the one- to two-week rotation during the semester is not sufficient. As result, if you come to a critical care unit as staff, you are blank when it comes to certain things that are considered basic things [such as] drug dilutions, basic ECG rhythms, terminologies, and those sorts of things. If that could be looked into, that people have an equal opportunity or something could be done differently, so that people get to spend enough time in critical care areas.

Some graduates advised putting more emphasis on a specific subspecialty of knowledge or more clinical skills. It is important to clarify that although some graduates made suggestions pertinent to the content of a subspecialty because they were working in that area, others suggested content that is not related to their work area. For example, Komal referred to more content in oncology and orthopedic subspecialties despite the fact that she was not working directly with such patients:

> We haven't been taught much about orthopedic patients or about oncology patients, so these areas should be covered in the curriculum. For example, we had only basic knowledge about what cancer is, the types of cancer, common signs and symptoms, and the three basic treatment regimes, but we have not learned in detail about different aspects of pain management or palliative care for oncology patients. We have not learned these things.

Similarly, Bahaar commented:

> In pediatric nursing there are few aspects that were not considered in the BScN curriculum, and those are very important in that setting; for example, dealing with pediatric CPR is very different from adult CPR, but it is not included in the curriculum.

Likewise, Huma emphasized the need to enhance pharmacological knowledge as a requirement of nurses at AKUH:

> Nurses should know more about medicine regimen and the pharmacokinetics of drugs. Sometimes the kind of math we learned in school is not helpful. Examples of math in our school [AKU-SON] are not reality based, but hypothetical. It would be helpful if they used examples from real work situations.

Diya offered suggestions to improve the maternal/child care course:

> For curriculum, some improvements can be made to the maternal/child care course; I mean, in its practicum. The students could be buddied with nurses to see how a delivery is assisted, how a nurse receives a newborn, and so on. We are taught these steps in our theory class, but we have not done it. Students should at least be given a chance to observe these processes and procedures.

Duad believed that nursing students in the initial year of the program are not used effectively in the winter and summer clinicals that are not graded or supervised by faculty members. Hence, he proposed a change in this practice:

> Right after completion of my first year we were sent to clinical settings—a two-week winter clinical and then a six-week summer clinical. At that time it was very difficult for me to work in a clinical setting because I didn't know anything except how to take vital signs and hygiene care. So at times we were really misused; we were used like labourers to bring food from the cafeteria, take this specimen to the laboratory, take this patient to radiology, and all these things. So that was very frustrating for us because we were not doing other work, just doing all these little kinds of work. We were basically replacing porters. They used to say, "The porter is not around, so you do the job." So I feel first-year students should not be sent to clinical settings.

### *Delivery of the Curriculum*

This category includes gaps that the informants identified in the delivery of the curriculum as well as suggestions for improvement, including increased opportunities or more time allocated to clinicals, the sequencing of the content, and the quality of the teachers. With a few exceptions, many graduates commented on the lack of graduates' ability and comfort level in clinical nursing, especially with regard to competence in their psychomotor skills. Hence, they proposed various ways to overcome this issue.

From Huma's perspective, the BScN program has placed more emphasis on theoretical work than hands-on skills, which, in her opinion, must be changed, especially during the clinicals, to free up more time for hands-on skills. Moreover, the duration of clinicals in the critical care area should be increased:

> We need to reduce the paperwork and have more opportunities for hands-on skills. We need to focus more on hands-on skills instead of the theoretical stuff, such as CCM [critical care maps] and NCP [nursing care plans], during the clinical timings. [In addition,] more hours of clinicals should be arranged for students in areas like ER or RR [the emergency room or recovery room], where one may have more chances of skills performance. I want to share that I am still not comfortable in IV cannulation despite having one-and-a-half years of experience, because in my area I do not have the opportunity to practice this skill. I think third-year nursing students should have a mandatory rotation in ER for at least fifteen to twenty days so that they can practice more skills, including cannulation.

Kiren contended that some policy changes are necessary to provide BScN students with more hands-on practice opportunities, because in the hospital they are expected to have good psychomotor skills as entry-level nurses:

> I suggest that the length of summer clinicals in year four must be increased to enhance hands-on practice. Besides this, during their summer and winter clinicals, students of years three and four should be allowed to demonstrate certain skills, such as cannulation and blood sampling. When you don't allow students to perform these skills, some do it secretively anyway, whereas some try to follow the set rules and policies, and hence they are disadvantaged. Some students are fearful and do not perform procedures without their teachers' supervision, but others do it. So we should have more realistic learning policies about psychomotor skills in our program.

Diya recommended better preparation of the graduates in terms of advanced cardiac life support (ACLS):

> I think students should be given a chance to observe or even work as a third nurse in ACLS. That kind of preparation is very crucial. Students should not be removed when a patient is being resuscitated, but at least be allowed to observe the process. If we were given a chance to stand there and observe, it would be helpful when we are required to handle crash [ACLS] in our practice.

Some graduates, including Hirah, Diya, and Kanwal, proposed that BScN students be given an opportunity to specialize in a particular area before they are assigned to work there as a staff nurse. Hence, they considered different strategies to bring about change, including some modifications in the senior elective to overcome its shortcomings. Hirah suggested:

> We should educate BScN students in a specialized area. For example, a number of students may be sent to each clinical specialty, such as oncology, cardiology, psychiatry, and so on. They should have a practicum period of three or six months in a specialty area. Although the senior elective may help to a certain extent, you are not always assigned to that area, which is a major issue at present . . . . I did my elective in ER, and that experienced was very helpful. That was my first priority that I had asked for. I was trained in the ER for six weeks, but then I should have been assigned to the ER, which wasn't the case. Therefore, changes should be made in the senior elective, such as increasing its duration. Students should be assigned to an area of their interest and later be assigned to work there.

It is important to mention that many graduates acknowledged earlier that they found it helpful to complete their elective on a unit of their interest and then to be deployed to work on the same unit. Like Hirah, Huma and Komal also reflected on some of the shortcomings of the senior elective despite its potential to assist the transition from student to staff nurse. Huma stated:

> Sometimes I think that if had I not had so many assignments in my elective, I would have learned more from my preceptor. Many times I couldn't give much time to my preceptor on the unit because of my graded assignments in the elective.

Similarly, Komal cautioned:

> The time for the senior elective is not sufficient. We have different objectives in this course; it is not only to focus on hands-on practice or patient care, but we also have to work on a project. So only half of the time is consumed in the patient care area and half of the time is devoted to project work. So that is why we don't have full involvement in patient care. I think the basic reason for the senior elective is to help BScN graduates, to see how much theory we have learned and what is happening in the hospital, to build relationships with the staff, and to acclimatize ourselves to the work setting. For the project we have to identify an area for improvement on the unit. However, as a staff nurse it is not guaranteed that you will be deployed to the same unit where you did your senior elective, so that makes me wonder about the value of the senior elective.

Diya recommended that specialized courses be offered to entry-level nurses to improve their efficiency as novice nurses:

> I think some kind of specialized courses in clinicals may help after joining the hospital, or even in the orientation program. One may design short courses of three- to four-months' duration that are area specific. Such clinical courses might focus on what is required of a nurse on a particular unit and how it should be done.

It is worth noting that the competency-based unit orientations (CBOs) at AKU are intended to achieve the same goal that Diya proposed in the form of specialized clinical courses for entry-level nurses. However, apparently the CBOs are unable to achieve their intended goal on all units, as illustrated in the third section of this chapter on the transition from student to staff member.

Kanwal and one of her other colleagues suggested that BScN graduates might be more confident as entry-level nurses if they had the opportunity to work longer on a unit before becoming staff nurses:

> If we could have more skills to practice, then we would be more confident than the diploma graduates. A colleague of mine and I think that all generic students [BScN] should have the opportunity to work on a unit for a longer time before they are assigned the title of staff nurse.

I asked Kanwal, "When shall this happen?" and she replied:

> We might do this in the final year of our studies or at the beginning of our professional career as the physicians do their internship after graduation. A number of BScNs could be allocated to a nurse manager for three to six months. So, for example, a number of fresh graduates might be assigned to the nurse manager of the obstetrics and gynae area. Those graduates could have a rotation on the peds/NICU and obstetric/ gynae units and learn the skills that they need in these areas. At the completion of this internship, they might be assigned to one of these areas based on the mutual interest of the graduate and the manager of that area.

Some graduates suggested changes to the sequence of the BScN courses. Kiren reiterated the suggestions that she had made earlier in the section on graduates' role preparedness. Komal echoed Kiren's perspectives:

> At present, courses on community health nursing, research, and mental health nursing are offered in the final year of the program; whereas the ACN and AHN

> [advanced concepts in nursing and adult health nursing] courses are offered in the third year, so we need to switch around these courses. I mean, courses that involve clinicals in the hospital or have hands-on practice opportunities should be moved to the final year instead of the third year of the program. If we learn things in year three and then graduate after a year, we are not able to utilize that learning effectively because we are not engaged in clinical nursing during the fourth year, so we should have the AHN and ACN courses in the fourth year.

Atya advised that "the professional development course should be offered in year one of the program, and this course should also be included in the diploma program because it is the main course that helps graduates to develop professionalism." Daud alluded to the organization of classes and clinicals, which left little time for students to study independently, especially during the daytime:

> The time for independent study is very limited. Sometimes we used to have classes from 8:30 a.m. to 5:30 p.m. So most of the daytime was booked for classes or clinicals, and very little time was left for independent study. We were given so many assignments, but we didn't have time to go to the library or search for journals or surf the Net or find other things. There should be some free hours during daytime for independent study, or students might try to find shortcuts to do their assignments, and they will not be of good quality.

A number of graduates commented on different factors related to the quality of teaching/learning practices at AKU-SON that they considered a hindrance or ineffective in enhancing the students' learning potential in the program, such as combined courses that are offered to students from different nursing programs and the quality of the teachers. With regard to BScN students' attending combined classes with other students, Aisha commented that they should have combined classes with post-RN BScNs, but not with diploma students:

> BScNs should work on their professionalism, because what I see is not the same as how we were taught in the program. I think now the BScNs don't realize the importance of being BScN students. They are now at the same level as diplomas because they have combined classes with diploma students. When we had combined classes with the post-RN BScN students, we learned from their experiences, and we recommended that this arrangement continue because BScN graduates are expected to perform at a higher level than diplomas. If BScN students are combined with the diplomas, their thinking ability will be reduced to the level of the diploma graduates when they graduate. They will not be thinking at a higher level as we used to do when we were combined with the post-RN BScN students.

> Although it was tough for us because our thinking was challenged by post-RN BScN students, we were making extra efforts to reach their level and keep up with the high expectations. Now the task of BScN students is becoming easier because they have been taught together with the diplomas or they have been blended at their level, so I feel the graduates of the recent cohorts may not have the same mindset as ours. Even the faculty do not realize that they are a different set of students. Maybe the faculty needs to realize and maintain some distinction between these students. When we joined, we really had a hard time to make them realize that BScN students are different. They need to understand that our program is different, and we need to market ourselves as different, but now they are successfully blending them with diploma students. BScN students need to improve their thinking. On one hand, in the work area they are expected to behave at a BScN level; on the other hand, they are not prepared for it.

To the contrary, at least three graduates suggested that BScNs should not have combined classes with post-RN BScNs because of the differences in the caliber of students from different programs. Atya recommended:

> Based on my experience of combined classes, I think that the BScN students' classes should be separate from the post-RN BScN students.' It is okay if they have combined classes with diploma students because both programs are at the entry level. They should not be combined with post-RN BScN students because they are mature students; they come with prior work experience.

Likewise, Aamna reported:

> When I was in my third year of the program, we had combined courses with post-RN BScNs. Despite the difference between students' caliber, we had the same courses. Here we were, young students who had just completed two years of nursing studies and were now in our third year, whereas they had very good experience in the hospital as diploma nurses and were working. We were just studying together but developing a similar understanding with them was very difficult for us at that time. So it was a strong feeling that even though the same course may be taught to students of both programs, it should not be taught as a combined class because we were a separate set of students, and our caliber was different from theirs.

I asked Aamna whether she was referring to specific courses or just any course, and she elaborated:

> Every course should be taught separately. The courses may be the same and taught by the same faculty, but students in different programs shouldn't be combined because they are different in terms of their experiences. . . . There are more disadvantages than advantages to teaching them in a combined class. One

> group may take more time and the other less time to understand the same concepts when everybody is taught together, and a few of the younger students might not be able to grasp that information. Sometimes in a large group it feels awkward to ask questions repeatedly, so a few of us decided not to ask any questions. But at that point we were missing some information.

Kiren provided further justification for not combining BScN students in classes with post-RN BScNs:

> We were merged with post-RN BScNs. Some of the faculty members in the ACN course were their classmates in the past, so there was some differential treatment that led to quarrels among us. We were literally exhausted and burnt out in years three and four of the program because of the fights and confrontations, and we gave up at times. No matter how hard we worked, post-RN BScN students were better than us because they had good relationships with the faculty as well as with the management staff in the hospital. Some of them were even working as CNTs or head nurses in the hospital. So that was a very challenging time period for us. I can say that the ACN course was like a confrontation course. There was discrimination between the post-RNs and the BScN students. Although we were merged as one class, we were treated differently. Teachers used to side with the post-RN BScNs. They would say that the post-RNs are good, the generics [BScNs] are not good. Now as a staff nurse, again we heard that diplomas are good, generics are not good. So such discrimination continued, first with the post-RN BScNs and then with the diplomas . . . . Even during our research course and in the community health course, the faculty members compared us with post-RN BScNs all the time. We thought that we had left that comparison behind in school, but then it continued on the ward too. It seems as if there is no end to this comparison.

Adil and Daud pointed out some of the shortcomings of faculty members that required attention to enhance students' learning potential. Adil expressed a concern about the quality of teachers in terms of clinical teaching:

> These days many teachers have changed. Some of the teachers have gone for higher education, some of them are assigned to particular areas, and some of them have gone to the university [AKU] campuses abroad. So because of these reasons students are disturbed. When a teacher teaches a subject for four or five years or if she is specialized in that area, it does make a difference to the students' level of satisfaction. Many students make an extra effort to study. Students are not totally dumb, but if they don't get a good teacher who has the ability to enhance the students' capabilities, then they won't be able to flourish.

Daud referred to teaching practices that he considered discouraging and as inhibiting students' learning ability:

> At times I felt that some instructors were not that competent to teach students because we were penalized for asking questions, or they would say, "We are not going to cover this detail in the classroom. Go and find out; this is your assignment." Okay, I understand that it promotes independent learning, but comments such as "You are asking silly questions" prohibited students from participating in class. At times we used to feel that we should not ask questions because if we asked questions, we were in trouble. Certain teachers might scrutinize students in the clinical setting if they ask too many questions in the class. They might say, "You are not doing anything" and refer to what happened in class. I think teachers should be trained to teach and should realize that students might ask questions. The teacher may not know everything, but they should not make such comments. Even if the teacher is very knowledgeable, with such comments it appears to the students that she doesn't know anything. So teachers should be confident to handle students. Though there were some good teachers who were very competent, some teachers were annoying. Maybe they were new or something.

I asked Daud whether he could recall a specific situation from personal experience in the past:

> Once a teacher was explaining fetal circulation, I remember this very well. I had done my prereading for the class and discussed some of those concepts with my friend, a third-year medical student, and I was confident that I understood that topic well. Later, when the teacher was explaining those concepts in the class, some students didn't get it, though the teacher explained it three times. So then the teacher was annoyed, and she asked "Is there anybody who understood this?" I said "Yes," so she asked me if I could explain it to the others, so I went to the front of the class. I don't know whether consciously or subconsciously I said, "Madam, the way you are explaining, it's actually not like that, but rather like this." There were some mistakes in her transparency, and I corrected them. The students said, "Okay, now we understand it." However, I think the teacher felt insulted, because later in the clinical setting I was in trouble. Believe me, I was in trouble! She nearly put me on a learning contract [for incompetence in the clinicals]. I am saying this because before that situation in the class, everything was okay, but after that she used to ask me for references on everything. Once I wrote a definition of *pneumonia*, and she asked for the reference. I told her that it was from the medical/surgical book, but she didn't trust me until I brought her that book. So after that I tried to stay quiet in the class. I think students have a right to ask questions.

Atya suggested that to increase the retention of BScN graduates, teachers could play a role in preparing them for career advancement in nursing by providing them with realistic information on career growth and by avoiding discriminatory treatment between diploma and BScN students:

> There is a need for reinforcement by the faculty to explain to students what will be expected of them initially in the workforce: You have to work at the bedside first; you need to develop your skills, demonstrate practical competence [in clinical practice] first, and then you may be eligible for a promotion to the next level. Without such understanding, things may turn out differently. For example, two or three graduates from our class have changed their profession altogether. One has become an air hostess, and one did a master's in epidemiology and now is a researcher . . . . Students in the BScN and diploma programs should be treated equally or seen equally in school because both are in an entry-level program; the only difference is that the former have a degree and the latter have a diploma at the completion of their programs.

Although Arzu echoed Atya's views on the issue of graduates' preparation for career development, she contended that the issue of BScN nurses' salary deserves attention:

> In my opinion students should be told clearly from the beginning what their prospects are and how they work to progress in their career. For example, with increments for experience and knowledge and competencies, they can progress in their career. Second, the salary scale should also be enhanced because on the unit, most of the time the BScNs are performing better than the diploma graduates, but there is no major difference in their salaries. So the issue of salary should also be addressed.

In addition to the above areas of improvement, Kanwal identified the need for an enabling environment for publication to make use of the extensive writing skills required in the BScN program:

> Another suggestion is that, although we learn extensive writing skills in our program, we don't use them after our graduation. If AKU-SON had a journal and encouraged us to publish from year one, then we would be in the habit of publishing. We could do that if there was an editorial board along with mentorship from the English faculty for publication. We need an enabling environment for publication. If we were in the habit of writing, then we could contribute to the professional nursing journals.

### *Summary*

In general, the graduates expressed a few concerns about the content of the existing BScN program, but they identified many factors that are relevant to the delivery of the BScN program and hence affect the outcome of the program for its graduates, such as their ability to fulfil nursing management's expectations at AKUH for clinical competence. Therefore, many of the graduates recommended changes to improve their ability in hands-on practice, such as in the areas of the allocation of more time for clinicals, the sequencing of the courses, policies related to students' practicum, and the quality of the teachers. It is evident that many graduates want to become experts in their work area as entry-level nurses. To achieve this kind of expertise, they proposed that graduates be allowed to spend more time in their designated area of work for a longer period of time during the program or just after graduation, but before they are recognized as staff nurses.

## Concluding Remarks

Narratives of informants reveal that they viewed competence as a composite of knowledge, skills, attitudes and behaviours required to provide safe and efficient patient care. Skills were not limited to psychomotor, but included of cognitive, affective, interpersonal and communication skills. Although clinical competence was deemed necessary, in addition, the ability to deliver holistic care that can achieve patient as well as self-satisfaction was considered important to become a successful nurse. Moreover, professional growth and development was highlighted as a key factor in being viewed as a successful nurse.

Being BScN graduates, the participants shared varied experiences with both positive and negative perception of self and others. In general, most of them felt proud of themselves and that they were valued in their families and community. However, for most of them, being a BScN nurse in AKUH was a challenging experience. Although, the participants recognized various opportunities and rewards that were bestowed to them being BScN graduates, various factors in their work environment affected their satisfaction in clinical nursing. Several of them expressed disappointment with the inconsistencies between what they had been taught to expect or assumed to have as BScN nurses, and what they observed in practice. Many of them imagined to perform at a similar level as post-RN BScN but soon realized the value of experience in nursing. Because of their qualification as a degree nurse, but as beginner nurse with no experience, they were associated or differentiated from others in the work environment based on their comparison with diploma and post-RN BScN. Most graduates were not happy with their financial compensation at AKUH, and hence several of them particularly male graduates decided to leave as they found better opportunities within the country or abroad. Nevertheless, many of them were not reluctant to return if the salary and work conditions improved at AKUH.

Most of the participants vividly recalled their initial experiences as new nurses and found it frustrating to make the transition from a nursing student to a nurse. Several participants reported that their enthusiasm and eagerness for becoming a professional nurse was replaced by fear, anxiety, and stress as they begun to face the demands and expectations of nursing practice in a real world. The graduates realized the importance of experience in clinical practice, and were overwhelmed by the sense of responsibility and accountability for their actions as professional nurses. Moreover, they found time management and command on the performance of psychomotor skills very challenging. In addition, the graduates' inability to perform psychomotor skills with same expertise as seasoned nurses was perceived by their supervisors as a weakness in their professional preparation, rather than as an expected state of professional orientation for entry-level nurses. Although each participant as a new nurse received some orientation at AKUH, it greatly varied in its quality. While going thorough the challenges of their adaptation as a new nurse, various factors in their work environment, such as workload, double shifts, and lack of collegial support influenced negatively on their ability to cope with the transition from a world of sheltered academia to that of the reality of nursing practice. In their perception they were being viewed with criticism and resentment rather than acceptance. Consequently, some of them were able to survive, while others decided to leave the institution.

Overall, the graduates had a positive perception of their program. They felt that the BScN program offered them a strong foundation in nursing and it equipped them with various cognitive skills as well as communication and interpersonal skills in addition to the psychomotor skills. Moreover, they developed teaching/learning abilities that they use for continuous development in their profession. From the graduates' perspective, strong theoretical knowledge, critical thinking, and interpersonal skills were their strengths, which apparently contributed to their success in a variety of nursing roles including, clinical, teaching, and management. With the exception of their learning related to research, most of the graduates were able to use the knowledge and skills that they had acquired or developed in their program. However, the perception of what has been most useful and what could have been most useful varied based on the informants' areas of work. Although the majority of participants expressed their satisfaction with regards to the content of BScN curriculum, they offered many suggestions to improve the delivery of the curriculum.

In comparison with BScN nurses in the general units, those participants who worked in critical care had a better perception of their role because they were more involved in their patient-care decisions or their input into patient-care decisions was often valued. The informants identified various aspects of their role or work environment that they thought needed to change for better patient care services, such as role autonomy or involvement in clinical decisions, the nurse-physicians collaboration, and the amount of workload. In addition, the participants affirmed that despite progressive changes in nursing education in Pakistan, nurses' work lacks its due respect and appreciation in the society which has negative implications for all nurses, but particularly those who are engaged in direct patient care.

# CHAPTER SIX:

# FINDINGS: THE SUPERVISORS' EXPERIENCES AND PERCEPTIONS

This chapter presents the analysis of the data, mainly with respect to the questions I asked of the supervisor informants. However, where appropriate, I have also integrated the graduates' responses as well as information that I obtained from my participant observation. I asked 12 questions of the supervisors, excluding the probes, and these are presented in the Appendix F-part B. For the purpose of analysis, questions and responses were grouped into seven sections that represent different topics. Hence, each section contains responses to one or more questions. Accordingly, these sections are: characteristics of competence, supervisors' perceptions of BScN graduates, effect of BScN graduates on patient care delivery, expectations and preparedness of BScN graduates, utilization of BScN graduates, perceptions of the BScN program, and suggestions for the BScN program improvement.

## Characteristics of Competence

To identify the characteristics of competence in nursing practice and the perception of the effectiveness in a nurse's role, I asked all of the supervisors two questions: "What abilities do you believe are necessary for effective performance in nursing practice?" and "How would you describe a successful nurse?" In response, the informants alluded to various elements of competence that are required for effective performance and success as a nurse. Although in general the supervisors identified similar elements of competence in response to both questions, there were some subtle differences with respect to their emphasis on certain elements. For example, many participants alluded to the importance of professional development to be a successful nurse compared with the abilities required to perform effectively in nursing practice, such as efficiency in skills performance. Considering the overlap of the responses, I present the informants' responses to both questions in two categories: knowledge and skills; and attitudes, values, and behaviors. However, to illustrate the subtle differences in their responses, I have also included subcategories for each question: the attributes for effective performance in nursing practice, and the attributes of a successful nurse.

### *Knowledge and Skills*

This category consists of the informants' comments related to professional knowledge and skills. In this context the term *skills* is not limited to psychomotor skills but includes cognitive skills such as critical thinking, problem solving, and decision making, as well as communication and interpersonal skills that are considered necessary in nursing practice.

#### *Attributes for Effective Performance in Nursing Practice*

For effective performance, Sairah suggested, "Besides knowledge and psychomotor skills, you should be able to solve problems and make decisions. You also need to have good organization skills to manage your time effectively." Although Mashal felt that theoretical knowledge is important for effective performance, psychomotor skills seem to be more important based on her explanation:

> Theoretical knowledge is an important feature of competence, which is required for patient care. If a nurse doesn't know about the patient disease process or doesn't possess sound theoretical knowledge, then she may not be able to communicate things properly or perform patient care effectively. She should also have good psychomotor [skills]. Nurses who are not very good at doing things often fail to integrate their knowledge into practice; nurses should be able to do things or demonstrate what they know. If they are very good in theory, for example, they know everything about cannulation skills; but they cannot insert a cannula properly, they often lag behind other nurses who may not be so good in their theoretical knowledge, but have good psychomotor motor skills.

In addition to good knowledge, Madiha emphasized the performance of psychomotor skills and applying knowledge in performing these skills to ensure patient safety:

> One needs to have good nursing skills [psychomotor skills] such as drug administration or bed baths. The nurse should be able work according to patient priorities and apply those concepts in basic patient care skills that ensure patient safety, such as those concepts used for the prevention of nosocomial infections, medication error, and bedsores.

A number of supervisors commented on the importance of critical thinking and learning abilities for rational practice, as well as continuous professional development. Meher contended that a nurse "should have the urge to learn and always be curious. She should ask what and why questions and thus have a scientific rationale for what she does." Likewise, Moona responded that nurses require "a sound knowledge and excellent skills, plus critical thinking, problem-solving ability, and decision-making abilities." Nidah also suggested that effective performance "requires good knowledge, and you have to be really enthusiastic to learn new things." Saher affirmed that "one of the basic things for nursing is your knowledge and skills, and the ability to work and progress in your profession." Sana also commented on "the ability for professional grooming. A nurse should be able to update her knowledge and skills on an ongoing basis congruent with her career goals."

Moona, Mashal, Meher, and Sana referred to communication skills. Moona simply said, "You should have effective communication skills," whereas others, in addition to affirming the importance of communication for effective performance in nursing practice, identified what is required for effective communication. For example, Mashal noted:

> I think communication is the most important feature that a nurse should have—communication with regards to not only communicating with others, but also understanding the dynamics of communication related to the patient and the patient's family or other members of the health care team who share the responsibilities for patient care.

Meher suggested that to be professional, a nurse must use a balanced approach to communication: "She should be assertive as well as polite and behave and talk professionally." Likewise, Sana also highlighted the importance of assertiveness in communicating, particularly with respect to patient advocacy: "I think assertiveness is also important; considering our male-dominated culture, a nurse should be assertive enough to deal with her/his colleagues and physicians for patients' rights." The phrase "assertive enough" points out the need for balance in communication, as Meher explicitly stated.

### *Attributes of a Successful Nurse*

With regard to being successful as a nurse, the supervisors explicitly indicated that possessing certain knowledge or skills is one factor in nurses' success, but that it is not sufficient; one must also be able to apply theory to practice to fulfill certain goals, such as providing quality care and, as a result, achieving patient as well as self-satisfaction. More than half of the informants identified the need for good knowledge, and a few emphasized the importance of interpersonal and communication skills. Some also considered problem-solving, critical-thinking, and time-management skills necessary to be successful.

For example, Moona commented on the need for relevant knowledge as well as skills for patient care:

> A successful nurse has knowledge and skills in her area or the patient care area, and she should have good communication skills and good time-management and good problem-solving skills in dealing with day-to-day problems and in dealing with patient care.

Half of the supervisors highlighted the need for nurses to demonstrate competency in their skills in caring for patients in order to be successful. For example, Meher noted, "I think a successful nurse is a nurse who knows her skills and performs them confidently and well, as well as . . . one who is satisfied with her own performance and who performs to the patients' satisfaction." Likewise, Saher described a successful nurse as "one who has knowledge of the profession and then . . . makes sure that she integrates her education into nursing practice, into the profession . . . [to be] competent, and whose clients are satisfied with the nursing care." Sairah expressed similar views and elaborated that quality patient care means fulfilling the needs and expectations of the patient and family, including their known or stated as well as anticipated needs. Nidah stated that a successful nurse is one

> who is competent to take care of a critical patient, who is confident enough to communicate and deal with critical situations, and who is sensitive enough to *sense* things from a patient's perspective. And at the end of the day if you feel satisfied, that shows that you are a successful nurse.

As stated earlier, some supervisors considered that continuous learning and professional growth were important for effective performance, others referred to professional growth and development as a necessary factor in professional success. Although some participants focused on the growth of the individual nurse, others talked about developing professional colleagues as well. Madiha thought that a successful nurse is able to grow in her profession: "Besides experience, . . . one who aspires to further improvement in her skills and knowledge." In other words, she said, nurses have to keep up with the advancements in their field and in the profession. Concurrent with Madiha's view, Sairah suggested that a successful nurse would be able "to develop another individual who is a nurse and guide them as a mentee in the profession"; and Sana asserted, "She should be a role model for . . . her colleagues."

### *Attitudes, Values, and Behaviors*

This category comprises the informants' comments about values, attitudes, and other professional behaviors that they considered important to be a professional nurse.

#### *Attributes for Effective Performance in Nursing Practice*

A number of supervisors talked about empathy in patient care as well as other values and behaviors such as honesty, responsibility, accountability, and a passion for nursing. Saher contended that without a passion for nursing, a nurse may not be able to cope effectively with the challenges of a profession that Pakistani society does not value:

> There are many abilities that are needed to be a nurse, but I will comment on the main abilities. One is caring, because if nurses are not caring and if nurses are not passionate for their patients, they will not be able to continue with their profession effectively. To me, this is the first value. If nurses believe in caring for others, they will be able to cope with the nursing profession because, in my opinion, nursing is a challenging profession that requires you to look after people who are strangers to you. This is something that is not easy because it is not much appreciated in this culture. So as a nurse you have to have internal satisfaction in caring for others.

Moona said, "Empathy for patients is a must for effective performance." Meher also identified the need for empathy, patient advocacy, and the ability to defend one's personal rights:

> I think a nurse should have the ability to feel the patient's pain and know how to deal with it physiologically and psychologically without harming herself. She should also be confident to fight for the patients and herself by utilizing her insights as well as her knowledge.

Sairah also emphasized advocacy for patients: "There are times when nurses hesitate to take risks in patient care decisions, but they should take risks in the interest of patient benefits." Mashal discussed the importance of sensitivity, empathy, and creativity in nursing practice:

> A nurse must possess some humanistic values. She must be sensitive and empathetic towards patients' pain, patients' suffering, as well as to the emotional responses of patients' families. So until and unless a nurse is able to empathize

> with patients' suffering, she may not be able to care for a patient in a manner that is required by a professional nurse. In my view, nursing cannot be viewed as a profession but as an occupation if nurses are not sensitive towards patient care. In addition, a nurse must have a vision and an innovative approach to patient care. Hence, the integration of research into practice is important. If nurses just do things as a job responsibility without being innovative, this profession will probably come to a halt. So innovation is an important factor in nursing practice.

In Madiha's opinion, for effective performance, "honesty and compliance with institutional policies and procedures is important. In addition, team work and professionalism are also important." Similarly, Sana responded:

> There are many other things besides your knowledge and skills required for effective practice or performance, such as honesty, responsibility, and accountability. A nurse should be able to listen to a patient and the family with empathy and be sensitive enough to handle the patient from a cultural and ethical point of view.

Saher and Nidah alluded to certain strengths and behaviors that nurses require to cope effectively in the work environment within the context of AKUH and/or Pakistan. Saher said:

> You should have the ability to cope with stress. A nurse should be able to cope effectively when faced with extreme situations or stressful work conditions; you need to know how to act in and react to those situations appropriately.

Likewise, Nidah observed:

> There are many things that you don't know or you are not prepared for until you begin to work as a bedside nurse, so you have to be patient, you have to be tolerant, you should be enthusiastic, motivated, and cooperative. You have to be adaptable to your work circumstances because many things that you are taught in your nursing school are theoretical or ideal. However, when you go to practice in a hospital in Pakistan besides AKUH, you have to adjust to the situation accordingly; you have to apply the principles of what you know, within the resources provided.

### *Attributes of a Successful Nurse*

The supervisors highlighted various values that they considered necessary to be successful as a nurse. *S*even of the eight supervisors talked about caring and its associated behaviors, such as sympathy, empathy, sensitivity, dignity, and respect. In addition, some supervisor commented on the required commitment and dedication to patient care to achieve patients' as well as self-satisfaction. Sana described a successful nurse as

> a person who is caring and who understands the philosophy of care and customer satisfaction basically, because if the customer [patient] is satisfied and patients are being handled properly, I think that . . . nurse would be somebody who knows all the rights of the patient, who is sensitive to patient care as well as to their ethical, their cultural point of view, . . . and also somebody who is a very resourceful person to the family as well as to colleagues.

Madiha also stressed certain values: "Successful nurses are those who do their work with honesty and sympathy and make the patients satisfied." To Sairah, honesty, respect, and dignity are important values to be successful; however, "honesty is a very core value because if you are not honest with yourself, with your patients, with your family, with your community, you cannot achieve much." Mashal concurred with these views:

> A nurse who is honest, who is committed and dedicated . . . . If a nurse does not posses these three qualities, she can never be a successful nurse . . . . I feel these are three key features, along with the other professional qualities that she must possess. These are the basic values that a nurse should have in order to be a successful nurse.

### *Summary*

The supervisors' accounts reveal that, in addition to professional knowledge various cognitive, affective, and psychomotor skills are needed for effective performance in nursing practice and to become a successful nurse. Likewise, a nurse must have certain values and attitudes and be able to apply her/his knowledge and skills to provide quality care that is satisfactory for the patients as well as the nurse. Since the supervisors considered effective clinical performance as a necessary condition to become a successful nurse, they commented on similar attributes in response to both questions with some subtle differences. For example, they alluded to the importance of knowledge related to patient care in response to both question, but to be viewed successful, Saher pointed out that a nurse also need to have knowledge about the "profession" to develop understanding of the profession. Moreover, the supervisors viewed continuous learning and upgrading of knowledge and skills important to perform effectively as a nurse;

however, a nurse must also have the ability to facilitate the professional development of her/his colleagues to be regarded as successful.

Like the overlap of attributes with regards to knowledge and skills, the supervisors commented on the same values and behaviors, such as caring, honesty, responsibility and accountability, commitment and devotion to the profession, for effective performance in nursing practice and to become a successful nurse. However, for the former, the supervisors emphasized the necessity for flexible attitude and internal motivation to cope with the stresses and challenges of day to day patient care pertinent to a given context.

## Supervisors' Perceptions of BScN Graduates

After seeking their description of a successful nurse and the characteristics of competence, I asked all the supervisors a grand-tour question: "What are your views about BScN graduates?" I used two planned probes with this question where appropriate: "What are their strengths, and what are their challenges?" The purpose of these questions was to elicit the supervisors' views of the graduates' competence. In response, the supervisors reflected broadly to reveal their perceptions of BScN graduates, including the graduates' professional competence. I also asked the supervisors to comment on the graduates' abilities of the specific skills, including problem solving, critical thinking, interpersonal skills, teaching and research abilities, safe and ethical care, and self-directedness. Based on the acquired data, I broadly categorized the informants' narratives on the above questions as professional competence, challenges, and attrition and retention of BScN Graduates. These categories and their subcategories, along with the participants' accounts, are presented below.

For the purpose of clarity, it is important to mention here that although supervisors were not asked to compare the BScN graduates with the diploma-prepared graduates, they often did so because it was very usual for them to compare the two, as Sairah said, "Somehow it is very natural that we compare the graduates of different programs…" In sharing their perception about BScN graduates in general, the supervisors were also cognizant of the differences among the individual nurses in addition to their professional preparation in specific programs, such as Madiha said, "I think definitely, they are different. I mean, some are very competent and very different from the others if I compare them with diploma. But some are like them, so there are individual differences as well."

### *Professional Competence*

In this context, professional competence refers to the capability to perform the duties of one's profession in general, with the required knowledge, skills, judgment, and interpersonal attributes of an acceptable quality. Moreover, professional competence is inclusive of but not limited to the ability of providing direct patient care or clinical skills. In view of this definition, I include the informants' accounts under various subcategories: cognitive abilities, communication and interpersonal skills, teaching and learning abilities, research abilities, leadership abilities, and patient care abilities.

#### *Cognitive Abilities*

This subcategory of competence includes the informants' comments about the graduates' theoretical knowledge and other cognitive skills such as, critical thinking, problem-solving, decision-making, and the application and integration of theory into practice.

***Theoretical knowledge and critical thinking***. Almost all of the supervisors acknowledged that BScNs have good theoretical knowledge, and six of eight appreciated their critical-thinking, problem-solving, and decision-making abilities. For example, Saher commented that, in comparison with diploma nurses, "BScN graduates have good theoretical knowledge, and they use their critical thinking skills." Meher observed that "they have the ability to think in a broader way." Likewise, Sana said, "If I compare it with others, I think they have better critical thinking to make patients care decisions." Sairah stated:

> They are more knowledgeable, they are good critical thinkers, they possess sound scientific knowledge, they know each and everything, they are very thorough about their pathophysiology, they are very thorough about their languages [nursing terminology], they are very thorough about their nursing care plans and everything.

From Mashal's perspective, critical thinking improves with experience, especially exposure to handling critical situations. Therefore, the level of critical thinking varies depending on individual experience. However, Mashal thought that, in general BScNs are inquisitive, which is an important disposition factor for critical thinking:

> Though some experience is required in regard to dealing with the critical situations, at least they have a curious mind, they never sit back and say "this is happening, so it is Okay" they always ask questions so, this provokes critical thinking but how well they perform is again situational; as well as, it depends from person to person but they have curious minds, they ask questions, they listen to things, they see things differently, plus they learn fast.

Moona alluded to another important factor of critical thinking, the ability to question. She described how BScN graduates use their critical thinking ability in patient care as well as its advantages in making patient care decisions:

> They do critical thinking—I often see them questioning the physicians related to the patients' condition as to why this thing is happening, "why is this patient in sepsis?" and "why is he/she being hypotensive," so they have good critical thinking as compared to others… Questioning helps because they clarify concepts and any misconception about anything…their critical thinking prevents some of the problems or complications in patients as they are able to identify things—like they bring things to the physicians' attention, such as altered lab values, so timely corrections are done in patient care decisions.

***Problem solving and decision making*.** When I asked the supervisors to comment on the problem-solving ability of the BScN graduates, Nidah responded that good problem solving requires good judgment and decision-making ability, and she thought that BScN graduates have these abilities. Moona elaborated on their problem-solving ability in patient care situations:

> I think they have quick problem-solving skills as compared to graduates of the diploma program, because they are able to analyze the situation quicker than other people, and they take quick action in some of the problematic situation—such as if a patient is getting destabilized. They are quick to assess and take action.

Madiha concurred with Nidah and Moona without any elaboration: "No doubt they have much better problem-solving skills. Meher and Saher reflected on the graduates' ability to solve problems in terms of handling patients' complaints. According to Meher:

> They are good in problem-solving when they are handling patients' complaints. Usually when there are problems, they know that it has to be resolved then and there. So they use their judgment and decision-making abilities in those situations, and if they need help they can go up to any extent to get the needed information

> and to resolve the problem; they don't worry about whom they are asking, they do ask because of their boldness.

Saher's response coincided with Meher's; however, Saher also suggested that mentoring might enhance the graduates' problem-solving ability:

> What I feel, like they know the theory part of it, I mean the steps for problem solving. So usually they have the idea, if something goes wrong how to approach it, for example, if a patient complains, they know the steps... They are able to deal with it independently when the supervisor is not around and later, they cross check that "this has happened, I did this, was it alright or did I need to do something else?" So kind of reconfirmation or seeking mentorship that is required.

Unlike other supervisors, Sana observed no difference in the problem-solving ability of diploma and BScN graduates: "I think there is not much difference between diploma and BScN graduates, I don't see a very polished, highly polished problem-solving skills in them [BScNs]." Similarly, Sairah described that although BScN graduates know the problem-solving process, in practice, diploma graduates are better than BScN graduates:

> I mean they have very good knowledge of problem-solving but actually resolving the problems is a concern, the practical implementation of that skill, they know each step of problem-solving skills but resolving a simple staffing problems take them four hours as compared to diploma prepared nurses who don't have sound knowledge of problem-solving but they are able resolve problems faster than BScN graduates.

***Application of theory to practice.*** Although all supervisors agreed that BScN graduates have sound theoretical knowledge, some thought they have difficulty in integrating their knowledge into practice. For example Meher revealed:

> They have the enthusiasm; they try for it, but need some coaching. We need to teach them how they can utilize their theory in practice. They have theory in mind, they know everything that the diploma person may not know and even I may not know it. If the patient is getting IV [intravenous] fluids and you ask them this much fluid is to be given in this many hours, they can calculate the hourly rate, but if you ask them "have you given this much fluid to the patient," they will say "No" ... So you want them to be vigilant about these small things, they don't want to go into the minute details, and it is in the proverb;"things appear good on the surface only," the depth is missing.

Meerah, a secondary informant who had worked at AKUH as a head nurse and had supervised BScN nurses, expressed similar views:

> Their theoretical knowledge was excellent, but application was very little. For example they knew the signs and symptoms of pneumonia but were unable to recognize it or assess it in patients. They knew how a post anesthesia patient may develop pneumonia, but yet were not attentive to the patients' post anesthesia position.
>
> Another example, I remember, one of them was reported to me for taking a specimen of urine from the bedpan for urine culture. When I inquired from the concerned BScN, she confirmed that. However, she couldn't recall how she was taught that skill in her school. … So because of their shortcoming in application of knowledge, out of four, two had an extended probationary period, that is, six months instead of three months.

In Mashal's views, BScNs might need some help to integrate theory into practice initially, but once they pass that phase, then they do extremely well:

> They have very good theory background. No doubt they have a very good theory background, but at times they find it difficult to relate that theoretical knowledge with a practical situation. So once they have been assisted and they are through that [phase], then they do excel. Then their problem solving skills are comparatively better, because they have been through the process of adult learning; so they try to solve the problem and they try to make decisions on the basis of what they had already learned and what they have already gone through [experienced]. So they utilize their theory and incorporate that with their existing situation and they do make sound decisions to enrich patient care.

### *Communication and Interpersonal Skills*

Almost all of the supervisors commented on the communication and/or interpersonal skills of the graduates. Although some viewed the graduates as assertive, others thought of them as aggressive, impatient, arrogant, rude, or hyperactive. The supervisors referred to BScNs as "vocal and expressive," with both positive and negative connotations. Some of the supervisors' narratives also reflected that there are more interpersonal problems between the BScN graduates and their supervisors than between the graduates and other members of the health care team. Some supervisors also reflected on the reasons for poor interpersonal relationships between the graduates and their supervisors.

***Communication skills.*** A number of supervisors saw BScN graduates as vocal and assertive about patients as well as their own rights. For example, Meher commented, "They are very vocal and expressive, they have clear expectations of themselves [what they want to do], which they usually verbalize on the first day [upon joining the hospital] and that is good." Mashal considered that communication is a strength of the BScNs. Nidah concurred with Mashal's opinion; she elaborated that BScN graduates are confident, which helps them to communicate with others:

> One more thing is that BScNs have the ability to speak up for their own rights and for the patients' right as well, they are very much confident. So when you talk about maintaining a relationship with others, with paramedical staff, with people of other disciplines, such as doctors, they are very confident in talking to them, they are very confident with talking to the consultants and their senior management. So communication is their strength. Communication and confidence, I see, are their strengths.

Madiha reckoned that, besides their knowledge, BScNs graduates are more confident than diploma nurses, which helps the BScNs to express themselves better. Madiha also alluded to the possible causes of their confidence:

> I think BScNs are more confident, they talk with the reasons. Their patient interaction is also good, they are confident in communicating with patient's relatives as well. They are also comfortable in communication with difficult patients, I think that they are good in handling difficult patients because of their knowledge and assertive communication skills, whereas if you see the diploma nurses, they are easily scared, but BScNs are confident even in their communication with the head nurse or managers. Because they are vocal people it helps in the unit as well because when everyone is quiet, you don't know how things are going, but when two people start speaking, others join and you know how things are going.
>
> I don't doubt differentiating between diplomas and BScNs because they [diplomas] are less confident and I had also discussed with BScNs about "how do you get this confidence," and I have heard from the diploma graduates that "these people [BScNs] are also in the same in the school, they are kind of ruling others, but we in the diploma program are fearful. So I think BScNs acquire this confidence from the school of nursing. Maybe their qualifications are different, they are enrolled in nursing school with intermediate and science background, so maybe this is in their mind, which makes a difference!

Saher had similar views to those of Nidah and Madiha, but unlike them, Saher thought that BScNs might need some external support to boost up their confidence in communicating with physicians:

> What I feel, sometimes they are able to kind of question the consultant, the physician very well, the only thing that they need is a confidence or a little push you know, that we give to them and then they are on their own. So maybe this is because of their theory component, their experiences in the program, or maybe this is because of their own critical thinking as a nurse. So that is something which is kind of there.

***Interpersonal skills***. Almost all of the supervisors referred to a negative aspect of communication that affects the interpersonal relationships of BScN graduates with their colleagues and supervisors. Nevertheless, in general, Saher had some positive images of their relationships with others:

> I feel as compared to the diplomas they have good interpersonal skills, they are able to have good PR with the consultants, with the colleagues, with the management. Because of their theoretical knowledge and self-confidence, they have the ability to question and challenge the practice, which they sometimes do in the combined rounds [health care team]. The doctors are kind of more comfortable with the BScN nurses at the bedside because of their communication level with them. So generally speaking, they are good and well prepared unless they have some attitude or some personal problem.

Moona observed that BScN graduates lack patience and are more aggressive than assertive, which affects their interpersonal relationship negatively:

> I found that communication skills and interpersonal relationships are not good in BScN graduates. They are very assertive but at times—I have found them very aggressive and sometimes it doesn't help them in developing relationships with others, they don't have much patience and they are very short tempered.... the diploma graduates are cooler and they have more patience but as far as I have seen that BScN graduates are hyperactive and aggressive people. So communication is the areas that they should be more prepared. They should be taught to be patient—they should be assertive not aggressive.

Sairah observed:

> At times they are more aggressive than assertive, maybe arrogant and rude, as I have observed. They are very assertive, but they also get conceited with their knowledge and skills because they think they are superior to other nurses, they know more about what is happening in the world and they are up to date with the

> literature. So they think they are the most superior group! At times they have even said this to their supervisor that they are more knowledgeable than them. … At least diploma graduates maintain a level of respect; whether they come from AKU-SON or they come from outside, they maintain respect.

When I asked Sairah for a specific example, she responded:

> I had two graduates like that who were extremely *Badtameez* [rude] and at times they behaved very awkwardly [tone of the speaker sounds angry] with their supervisors, such as their team leader or even the head nurse. I observed them yelling at others because they do not hesitate to tell their management that they are more competent. … My philosophy is that a respect level should be maintained while concerns are being resolved between the team members. But that was not the case with those two individuals. However, we found that those two individuals had very different family backgrounds too. So I cannot really generalize this for all the BScN graduates.

I asked Sairah, "How do post-RN BScNs feel about their knowledge?" She replied:

> They take pride in their education, but they are more experienced and practical in their approach because most of them have already worked at the bedside, so they know the ground realities, unlike the BScN graduates who rely more on the bookish knowledge, and the implementation of which is minimal in practice. BScN graduates usually tend to make changes by themselves and they think they can do it by themselves, so they do not involve other team members, they do not involve the management. Usually they don't come up with practical ideas as the post- RN BScNs do.

Moona and Meher commented that BScN graduates initially keep themselves at a distance from other nursing members of the team, particularly nursing assistants, because they think of themselves as superior to others; however, later they realize the value of team work and improve their relationships with the team members. Meher also expressed, "They don't mix with people like nursing assistants, they feel a bit superior, but after a while when they see that they need the help of each team member in patient care delivery, then they mix." Likewise, Moona commented:

> I think, to some extent they feel superior to other nurses, they say that "we are not from the diploma program," . . . and because of that, I often see some group dynamics. Like in our area we have a combination of other health personnel, such as nursing assistants and technicians, so initially, BScNs don't mingle with other group members and they keep themselves segregated. BScN graduates have

> difficulty in adjusting in the group as they think of themselves as superior to others. . . . But "when you are working in a team for patient care, you have to make friendships with others because they are senior people on the unit and they can guide you about the systems and how things are worked out in this unit." They do learn that later when they realize that if they keep themselves separate then they will suffer because others won't help them in crisis situations, so with time they understand this and mingle with other staff, they understand that teamwork is important!

As noted earlier, Madiha was appreciative of the BScN graduates' ability in communication with patients and their relatives, but she shared Meher's, Moona's, and Sairah's observations with regard to the graduates' interpersonal relationship with their colleagues. Madiha gave some examples of the BScN graduates' interactions with their colleagues and supervisors:

> They are more confident and vocal, they are more vocal! So most of the time they lack in interpersonal skills because they don't know that there is a fine line between assertiveness and aggressiveness and sometimes they cross that, as a result their interpersonal skills get affected with their colleagues.
>
> There is a way to say things to your colleague if you know something that they don't know. The way BScN graduates explain things to their colleagues appears rude, it is not a humbling way but rather teasing way which affects their interpersonal relationship, that's what I think. For example while taking over from a colleague, they may say, "Oh you don't know this thing; this is such a simple thing!" So the other person gets hurt and the next time he/she will be very quiet in this type of scenario. Likewise, if you tell them [BScN graduates] that they are expected to do a double shift; they will say, "Now? I won't do a double. No." So they are very straight forward to say this to you [supervisor], which doesn't seem nice. The other staff then say, "Every time we end up doing a double, why don't they do it?"

I then asked Madiha whether BScN graduates lack diplomacy in their communication. She responded, "there are many scenarios like that in which they say 'No' to you. They think, 'Nothing will happen to us.' They don't care." Although Saher had identified many positive aspects of the BScN graduates' communication skills, to a certain extent she also concurred with Madiha in terms of their behaviour with supervisors. Saher pointed out, "I understand, the individual rights, but we also have a commitment to patient care." In her view, sometimes patient care is affected by the carefree attitude of BScN graduates:

> If we are short of staff and ask them to do a double, sometimes they will do it without any question, sometimes what they won't because of some personal reason and as a supervisor we feel that they should do it, they should understand that we cannot leave the unit. It is also kind of disrespecting the supervisor because they are refusing, but they [BScNs] are the kind of people who don't take orders, and sometimes they even don't take the request, whatever they want they will do it, they don't even think of what they are doing and what they are saying and who is suffering. So at times this have a negative effect on patient care, maybe only 10% of the times but it happens. So that is something which is not good.

Unlike Moona, Meher, and Madiha, Mashal considered BScN graduates' behaviour acceptable with their colleagues, but not with the supervisors:

> They are equally good as diploma nurses, they are equally good with—whoever is in their team, but I have found one difficulty with BScNs, they have a little arrogance [chuckle], I would say a little arrogance in their approach to their supervisors. I have found this in a few of the BScN graduates, but I have not observed this in diploma graduates that they are bit arrogant, or sometimes rude to their supervisors.

I asked Mashal whether this behavior is specific to the diploma prepared supervisors, and she responded, "Not exactly; it could be any supervisor. They have some difficulty in accepting criticism. It is a problem with many of them that they do not accept criticism." Mashal described some other possible causes for this behavior:

> Probably, they have never been ever criticized in their program [BScN], most of the times, they are treated as an adult learner, so now, [in practice] they don't want to be penalized, they don't want to be pointed out for particular things, they want to be independent. Or it may be because of their educational background which matters, or it is their family upbringing which matters, there could be multiple factors; but they have difficulty accepting criticism.
>
> I would like to mention here, we had two cases like that and in both situations those staff left their jobs just because they were asked to do things in a certain way, which they were not doing. So, I personally found it very difficult convincing them that they need to accept certain supervision and criticism, which was positive criticism to modify their practices, but their perception of criticism and supervision was very different, so we had lost two of our staff in these four years because of this issue—probably it was the first cohort of graduates; as I mentioned earlier they had in mind that they would be treated as first line management or given a position as soon as they went to the units, but when they were explained, like "No doubt there is a difference between you and diploma nurses, but again you are a novice nurse, so novice nurses have certain limitations. So you need to realize those limitations and you have to improve on those

> limitations," they then they realize, but some people have difficulty realizing those limitations.

Sairah also alluded to some interpersonal characteristics of BScN in comparison with the diploma graduates. In addition, she reflected on the possible causes of these characteristics:

> We find diploma graduates more respectful, courteous, and polite than the BScN graduates. . . . Diploma graduate accept things better compared to BScN graduates, BScN graduates will first evaluate and judge the consequence of what you say to them, and then say may say okay or fine. But the diploma graduates will accept it straight away. These differences may be because of their family background, their social status, and their general education. As most of the diploma graduates may come with matriculate level compared to BScNs who, these days, come from very accredited colleges and universities. So maybe that is causing the difference.

Saher similarly thought that BScN graduates do not accept criticism easily; however, Saher had a different perspective:

> If a patient has some concerns about them, sometimes it is difficult for them to take it positively. Because we assign them as a team leader and we rely more on them. So maybe that's something, which gives them an idea that everything is positive in them and there is nothing which is negative, so sometimes they get defensive, or they get negative towards management, towards the colleagues that you know "if I am doing this, if I am taking additional responsibility as team leader, so "why can't you excuse me if something didn't go right?" which is not possible from a personal point of view.
>
> Though it depends on the individual's nature of course, in general, if we tell them something which is an area to improve, it is difficult for them to accept it, and you know we have to tell them in detail [why it is not right] because they want to know what exactly we want from them. So we need to explain to them in a more elaborate manner as compared to diploma nurses. Like they don't take it just like that without an explanation, they don't take it, we have to give them more details, and we have to give them more time for acceptance, that you know this is something which we want, and then they improve.

I told Saher that some of the head nurses think BScN graduates are arrogant or rude and asked her views about this. She responded:

> I am not sure whether that is arrogance or not, but I feel that it's their confidence, maybe they are over confident with things. Like as I said earlier, they feel that they are better than other nurses, and usually they have good self esteem. We can't say that 100% of the BScN graduates are arrogant but maybe 5 or 6, I can

> think of one or 2 at maximum, who could be viewed as arrogant, however, when we trained them, or make them reflect on what they do, I feel that they are able to improve, but you need to approach them tactfully. You have to approach them with frankness and decrease that gap, which exist between the management and the employees in our culture. So you have to develop a trusting relationship with them before you criticize them. Sometimes, you may have to pamper them because they are not aware of what they are doing, and this may be because of their family background, or personal characteristic, but not because they are graduates of a certain program. I think there are many other factors that may make them arrogant or offensive and personality is one of those factors. But yes, they are more confident, they are more assertive and sometimes they pass the line of assertiveness if they get angry. So when this happens, then they complain about everything, they can be demanding and very assertive in their questioning skills. They are not afraid of questioning or challenging their supervisors. . . .
>
> But as a supervisor, I don't see it as something negative because they have the right to ask and if I am logical in my thinking, I can convince them. I am not sure, but generally speaking supervisors feel threatened which I don't feel anyways, but you know, if as a supervisor I am a BScN [post RN] and if the bedside nurse is also a BScN, we are parallel in our qualification, of course there is a difference in our experience, but if she is more sharp considering her knowledge and skills with new technologies, and she knows ways about her career growths and all, then of course she will question things. So if I am logical to her as a supervisor and I am kind of able to convince them from a policy point of view, from my experience point of view, then they are open to it, they would take it. But if I don't have a rationale to convince them, they will not accept it, but pursue it to the next level of management, they will go to my supervisor, questioning why this has happened. So that's why we have to be more tactful and more alert with them. And one more thing, generally speaking, as supervisors, we feel that the employee should do what we say. I think that we should not have this approach. I am not sure why we think this way!

I inquired, "Do you think a generational gap has any influence on the differences between graduates and their supervisors?" Saher elaborated on her answer:

> Yes, I think there is a generational gap also. If you think of their admissions process into nursing, we select those for the BScN program who have better capabilities. When I take the interview, of course I see their sharpness, their assertiveness and communication skills, so we wanted them to be assertive. We take them in the program with better skills and then polish them further in the BScN program. So of course they are more assertive, more confident in themselves internally because they know what their strengths are. Whereas, most of the supervisor began nursing through a diploma program ten or twelve years ago and then went for a BScN. Usually we compare them with us, we didn't used to do that, why are they doing it? They are able to question their supervisors, but we are not able to do this with our supervisors even after ten years in nursing, so how come they are doing it? So maybe that is a generation gap, something which

> is apart from the culture, apart from their training in the school of nursing. But we wanted them to be assertive, so I guess as supervisors we need to take it and we need to broaden our views.

Regardless of its reason, from Meher's perspective BScN graduates are weak in their understanding of cultural norms in regards to their interactions with elders, such as the need for obedience. However, like Saher and Mashal, Meher also thought that one has to be tactful in dealing with BScNs, particularly in criticizing the weaknesses in their performance. Meher supported her view with a specific example:

> I think they have little difficulty in understanding the norms… they think that they can change everything but there are some norms that we cannot change…. they are more vocal and they have less tolerance. I think it also involves the factor of obedience as well, if senior people [in reference to age or authority] to you talk more, you should keep quiet, but because these graduates are more vocal, they verbalize their feelings and express them. The same behavior is exhibited in patient care, for example, if a patient complains of something, the use of words like "sorry." comes later, but the argument comes first. "I haven't done that." In ### [unit name], we don't say things so directly but with diplomacy. So they [BScNs] require more training for such things. Diploma nurses—are more obedient than the BScN graduates, maybe they keep quiet because they are scared, but BScNs are not like that, it takes time for them to understand. I think they take things very personally.
>
> Once on my patient rounds, I asked the patient how everything was. "Are you satisfied with the care and services, do you have any suggestions to improve our care?."he said, 'the people should be more organized and come equipped with their supplies when they go into a patient room." Although he did not elaborate, I knew why he was saying this. I noted that his pillow was without a cover. So I went to the assigned nurse [a BScN] and said "you didn't give a pillow cover to a patient." She responded "Is it a big deal if he hasn't received his pillow cover for 10 to 15 minutes?" I said "it is not a big deal, no one is harmed, but the patients come to AKUH with a certain expectation, thinking of ideal care, so only that ideal is affected, otherwise nothing has happened. Then I asked her, what will you do now? Then she realized, she smiled and said "Sure, I will go and apologize that I had forgotten it, and give him the cover." So I instructed her that please don't give him an impression that I have spoken to you. … If this was a diploma nurse instead of a BScN, her response would have been, "Oh sorry, I will do it right now" they won't question what, why, and how. Sure, there are good things in BScNs but I think they have difficulty in accepting criticism.

***Teaching and Learning Abilities***

All of the supervisors were appreciative of the graduates' strength in this area of competence; they related the graduates' strength in teaching/learning to their other characteristics: a sound theoretical background, motivation, confidence, self-directedness, and awareness of teaching/learning principles. Nidah responded, "BScN graduates are very good, most of the time, and their strengths are that they are motivated, they are enthusiastic, and they are ready to learn, so teaching them is a bit easier than teaching the diploma graduates." Likewise, Mashal identified that BScNs are mainly self-directed; hence, they can learn better with little facilitation compared with diploma holders. Moreover, their educational backgrounds contribute to their understanding of the complex concepts of patient care:

> I found BScN graduates better than diploma graduates. The first reason is that BScNs are more self-directed; they are more mature and they adopt things very quickly. . . . They take things very positively and they don't need to be pushed in order to learn things, rather facilitation to learn the things. So . . . I have not found difficulty in supervising BScNs, because, once they are facilitated towards a goal, they strive in order to achieve those objectives, so yes, they require facilitation, they require mentorship, but it's their equal contribution towards their growth and development. Second, most of the BScNs come from very good schooling backgrounds, most of them have studied sciences, physics, chemistry, and biology, [as their major], so understanding the complexity of patient care in critical care situations becomes easy for them because their educational backgrounds help them to adapt faster.

Likewise Saher observed:

> BScN graduates are very good in teaching whether it is teaching the patients or the staff—which we do for staff development. They are able to explain things very well to the patient, to the family, and to the staff. They are good in teaching because they have good theory, they are more capable of doing things on their own, and they are self-directed, so we rely more on them for teaching. They are also good in mentoring and preceptorship, in fact they are outstanding for utilizing their teaching learning skills.

Moona commented:

> I think, because their knowledge is good, they involve themselves more in the teaching area, diploma graduates don't involve themselves, sometimes they attend group teaching but don't participate much, but BScNs take initiative for teaching, they go and find out things or search for the literature and present it to others.

Madiha believed that "BScNs are good in teaching because their knowledge is better and they are confident and vocal, so they feel comfortable in teaching. Whenever I observe them teaching, they explain things well to colleagues or patients."

Though Meher's views concurred with those of other supervisors in regards to BScN graduates' teaching ability, she wished that they could have been as good in their practice as they are in teaching:

> If I ask a diploma nurse to teach their colleagues, they may respond: how will I do this, but BScN graduates are good in that. They are not reluctant to teach others whether colleagues, patients or their families. They are very good in teaching sessions. They can give thorough sessions, but when you see them in their practice that is not—perfect, no body can be perfect, but it is not up to that standard, to what we expect, as they teach it nicely, they should be able to practice it too, but that is not the case.

Overall, the supervisors agreed that BScN graduates demonstrate good teaching/learning abilities. Their competence in teaching was also evident in their formal and informal teaching roles. For example, in June 2006, of the 20 clinical nurse teachers at AKUH, six (30%) were from the BScN program; and of these six, three were working in critical care areas including the cardiac/surgical unit, the neonatal intensive care unit, and the recovery room. Likewise, 7 (22%) of the 32 preceptors in the BScN senior elective in 2006 were from the BScN program, and all 7 preceptors were working as staff nurses at AKUH.

### *Research Abilities*

All of the supervisors agreed that BScN graduates do not make use of their knowledge about research. Some supervisors thought that the BScN graduates may take the initiative to conduct small research projects or conduct literature reviews, or participate in an existing project, whereas others thought that there are not many opportunities available for research. They contemplated that lack of interest, workload, and time are the possible reasons for lack of initiative among the BScN graduates for research related activities.

Sairah and Meher said that the graduates have knowledge about research but they are not using it. They also indicated that the graduates would be supported by their management if they took initiative:

> Although they submit good proposals for projects in their research course; the implementation of research in the clinical side is zero. Even if I have personally asked some of the BScN graduates, "lets come up with a few clinical projects," simple research projects but they don't, may be it's due to their workload or non availability of time, or I don't know what. Generally they don't take initiative; however, last year, one of the graduate took the initiative, she wanted to have a lit review about an aspect of bed sores/ pressure sores, and that individual asked me for study leaves which I approved. And that was very beneficial for the patients. So I think the BScN graduates need to take the initiative and communicate their plans if any. . I can also reinforce that in my unit. I will go back and communicate to them again.

Likewise Meher stated:

> I have not seen any of my RNs doing research, but I say to them that "you are a BScN graduate and you know how to do research, I have done a course, but it was many years ago and I have not done a BScN," so you can teach me and we can work on it, but you should start a project because you know better then me, but still after such encouragement, I don't see them doing it.

Mashal suggested that, although BScN graduates are not capable of conducting independent research, they could participate in the existing research projects in the unit, but the graduates were not currently involved in any of those projects:

> I have not found any BScN graduate participating or taking initiative about a research activity. I believe one of the major differences between BScN and diploma is research or their anticipated participation in research, but I have not found any graduate doing that. Probably it's a workload or work expectation that hinder their participation or probably they are too tired from their work responsibility and they don't have enough energy to participate in that.... they would not be able to conduct research independently because they are not prepared for that, but at least they should participate in it, such as in data collection or compilation. Right now we are having three or four research projects in our unit and we do not have any BScN graduate participating in these.

Nidah and Saher indicated that there are not much opportunities or time to think about research even at the management level. Saher said:

> I am not sure whether we have anyone who is involved in research while working at the bedside because we have a lack of time, even nurses in management don't get time or opportunities to be involved in research. However, those interested in research, do some kind of research work, like the quality circles projects in which bedside nurses are involved on a voluntary basis. So they may get the opportunity there. I feel BScN graduates are interested but sometimes it's difficult for them to

> participate in it because of the time constraints. We need to work and improve in this area.

Nidah added: "We never get a chance to do any research because we are so busy with the routine things; most of the time we are busy arranging staff schedules and we never get an opportunity to think about these things [research activities]." When I asked the supervisors to comment on specifically whether the graduates are able to keep themselves up to date with the relevant literature, Meher and Nidah said, "its not very much, that even doesn't happen." Madiha added:

> Everything requires time. I think they don't get time or they are busy with other things. They don't take initiative in research. Though, they could at least conduct small scale literature reviews, but I think this is a not a habit for them. So you see them at the same level as diploma.

However, Moona thought that the BScN graduates in her unit keep themselves current with the literature:

> I haven't seen them involved in actual research, but use of the research information, they do, and they are good in that! They will go on the internet, find information and tell me about what they found. They will bring the literature and involve themselves yeah. They keep themselves current or informed.

Mashal's views coincided with those of Niadha and Meher:

> Though BScN graduates are so much used to do literature reviews in their program, once they are in the job life, they don't take initiative in that. I don't know how they do it in their student life, I have hardly seen BScNs graduates bringing the articles and sharing information, like "see I have read this article, I have found something new, and I want to share this new research with the group." Rather I usually take the articles and share with them. So, I have not seen them being very motivated towards evidence-based practice. Yes, they would accept whatever is provided to them but, as far as literature review and on-going evidence based practice review is concerned—they are not very motivated to do this.

I asked Mashal "Do you know why there is such change in the graduates' behavior in the work place?" She responded:

> Probably we are culture oriented people. We follow the same practices that we see happening around us. Western hospitals have a very different culture, nurses would always be carrying a pocket guide, or pocket book with them and they

> would always refer [illegible] it all the time, but here, I have never seen a nurse carrying a pocket directory. … In our culture, the approach to learning is very different, there is more emphasis on teaching than learning, the culture of learning is limited, like self-directed learning or adult learning, like going to the library and keeping yourself abreast with the recent literature as to what is new, what I must know, what I don't know, that kind of curiosity is somewhat not there, perhaps due to work load. Nevertheless, if you provide them things to read, then they do read. So until we make a shift in this culture, the goal for evidence based practice seems difficult to achieve.

### *Leadership Abilities*

In general, all of the supervisors except one considered that BScN graduates have good leadership potential because they possess many of the qualities that are important for leadership, such as confidence, risk taking, assertiveness, critical thinking, and decision making. In addition, they are fast learners; hence, they are easily groomed for leadership in the clinical areas. Of the eight supervisors, five acknowledged that they preferred a BScN graduate to a diploma graduate for a team leader. Most commented that BScN graduates are able to actualize or enhance their leadership potential when they are assigned to work as team leaders in patient care services. Sairah reflected on the graduates' leadership potential:

> I think they have very good leadership potential in a sense that they possess some of the skills required for leadership, such as decision making and problem solving which could be further enhanced because they are motivated to learn, they show a sense of responsibility if you assigned them in a role, they will fulfill it.

Moona expressed similar views:

> I found they have better leadership abilities compared to graduates of the diploma program, . . . like decision making, problem solving, critical thinking. They also possess good knowledge and learn fast, so they tend to develop leadership skills faster.

Mashal asserted that in addition to their communication and collaboration abilities, BScN graduates are self-directed; hence, they require very little training to demonstrate their leadership potential:

> They tend to become team leaders quickly, they demonstrate good communication and interpersonal collaboration with the different teams that we have to work with. They know how to tackle the things diplomatically [chuckle]

> and professionally as well, so they are very smart in that. "How to get things done from your team or how to get things done from others, which are again parallel or superior to you," so they are good in manipulating situation as well [laughing], like they are very good in regard to communication and interpersonal collaboration. Often they don't need to be trained in a certain way that "okay, if you have this situation, you will do this," rather they observe and learn, they behave in a professional manner, which is again a quality of a good leader. In addition, BScN graduates can handle work stress very appropriately and professionally. For example, one of them was doing so well that only after 2.5 years in the unit, she became the clinical instructor and she is doing very well. She knows when to ask for help, how to deal with crisis situation, and how to handle the stresses of professional life.

Nidah's views were similar to Mashal's, and she highlighted the thinking ability and communication skills of BScN graduates compared to those of diploma graduates. She also described the outcomes of these differences:

> Communication is an important factor of leadership and they have good communication skills. They have the ability to lead a group no matter how much experience they may have. If we compare a team leader with the BScN and the diploma education, we find that BScN graduates have strong communication skills which help them in getting along with others, but at times it becomes a hindrance because they are assertive. The diploma prepared team leaders follow others, what others want, they take time before they are able to implement their own thinking, or they easily accept others point of view; whereas BScN graduates will think a bit whether what is said is right or wrong. They have the quality of taking initiative; they have thinking power which is not there at times in diploma graduates. Diploma graduates are submissive, whatever you say they will follow that. BScNs question things, for example, as a supervisor if I ask a BScN to do certain thing, she may show me her job description, her rights and responsibilities; on the other hand diploma will do it because the supervisor is saying it, "so lets do it." Whether they do it to respect the supervisor or because of something else, they do it, but BScN are very assertive, they don't do it [if it is not right from their perspectives].

Meher concurred with Mashal and Nidah about the strong communication skills of BScN graduates and the relationship to their leadership abilities; however, like Nidah, Meher also pointed out that the graduates may face some difficulties because of a lack of communication skills, as detailed earlier in the interpersonal relationship subcategory:

> They are good at that; even if they are not in a position, they are very good in their leadership skills. Though at times their communication skills maybe a hindrance for them, but over all they have good communication skills with the

> patients. Initially, they may have some difficulty, but later they develop very good rapport with the patients as they have good articulation skills, they the don't feel shy—using comfort sentences, like they will say to a patient "you look fresh today, Mr So -and-So, I think you will be able to do this better today." This kind of articulation lacks in the diploma nurses because they feel shy, but not the BScN graduates. This is very good! as you know many issues could be resolved with effective communication skills. They know how to communicate, which helps them to be a good team leader because they can satisfy patients. In addition, they learn fast, so they pickup things quickly and develop fast.

Though Madiha was in agreement with other supervisors that BScN graduates could perform better when assigned as a team leader, she indicated that some BScN graduates do prefer to work at the bedside:

> They [BScN graduates] are different in terms of knowledge and their confidence level, so how they approach and prioritize a problem differently than others, and sometimes I think they are more mature… we prefer them to be the team leaders because they have more knowledge and they have team leadership skills, and they may have had more exposure to a unit if they had done their electives in the same unit. However, some BScN graduates also refuse to take the responsibility of leadership because they prefer to be at the bedside. So definitely individual differences are there!

However, Saher reported that most of her team leaders are BScN prepared:

> Generally speaking, in my areas if you see, the people who are working there as team leaders, most of them are BScN graduates, and of course they are sharp. I have seen that they are more critical in their thinking, and they are kind of more capable to work as a leader within six months time. Sometimes because of the shortage of nurses, we kind of just give them this challenge of being a team leader, and they are able to perform in a more proper manner, in a more effective manner as compared to any other RNs because they have more polished leadership qualities and management skills . . . . They are able to cope with or they are able to grasp instructions that are given to them, they are able to understand things by observing the head nurses. However, they just need a little boost or push for that, but they have good confidence in themselves to be a good leader.

When I asked Saher to elaborate on what she meant by "a little boost up or push," she explained:

> Being a team leader is a huge responsibility in the big [60-bed] units, so when someone is initially assigned as team leader, the head nurse or the CNI of the unit asked them for a briefing of their shift and to share their feelings because

> sometimes they get frustrated, sometimes they get stressed up because they are very busy. Though the head nurse or CNI try their best to appreciate them, at times they forget to do so if something went wrong or was found negative in the shift. The head nurse can ask the team leader for more information or reasoning if something went wrong in the shift, like she may question the team leader "tell me why did it happen?" without even realizing that the team leader was a novice person, and she needs more mentoring. So this could be upsetting for a novice team leader because they get questioned for things that go wrong but they don't have any incentive for being a team leaders, I mean the extra responsibilities that they are given. So at times BScN graduates question "why should we do that, we are not getting any incentives for doing that?" and they may begin to explore other opportunities and may resign [AKUH]. So we [the management] need to come up with some kind of positive reinforcement and appreciation for them to boost their morale and so they can continue with the extra responsibility. However, if someone either a diploma or a BScN graduate becomes team leader after working for three or four years on the unit, they are aware of the system, of the unit culture, of the people whom they are working with, and have good PR with the head nurse. So one can work in a more relaxed and comfortable manner, but this doesn't happen with the new graduates who are assigned to work as a team leader. So we need to boost up their morale just to make sure that they are retained.

Unlike other supervisors, when I asked Sana for her views on the leadership abilities of BScN graduates, she responded, "I have not really experienced such a thing with them." Nevertheless, it is interesting to note that Sana does have BScN prepared team leaders and a clinical nurse teacher in her area, which I learned during my participant observation in the hospital.

### *Self-directedness*

Some supervisors including Mashal, Nidah, and Moona had already commented on the self-directedness of BScN graduates (noted earlier) when they were asked to comment on a list of specific abilities of the graduates (question 8, in Appendix F). However, some supervisors added more thoughts. Mashal said, "Usually, they are self-directed." Moona affirmed, "I think they need less supervision as compared to the diploma graduates, they know how to go about things and find their ways." Saher reflected:

> I feel they are independent, they need less training in terms of adjustments to the units, we usually have three month time for the competency based orientation in the unit, which they do in one month or one and half months time, and they are comfortable with that.

Madiha stated, "Yes, they are [self-directed], but at times they need supervision as they have kind of a carefree attitude; they have shortcomings in terms of responsibility and accountability" Likewise, Sana said, "I see no difference [between them and diploma graduates]. They equally require the supervision of the clinical nurse teachers and the head nurses." However, Sairah responded with a meaningful smile, "They are highly self-directed, highly, highly, because they know what they need to do." So I asked Sairah "Do you have something in mind when you say that they are highly, highly self-directed?" She explained:

> I was just thinking of all the individuals [BScNs] whom I came across. They have their goals and planning to achieve that, I mean they have done it for the next ten years. So that's the reason I was smiling at their self-directedness, they are highly self-directed. They know what they need to do and they know what steps they need to take to achieve it.

It is worth mentioning that the supervisors' comments in regards to self-directedness varied based on their reflection of the graduates in patients' care, teaching/ learning abilities, and career development.

***Patient Care Abilities***

In regards to patient care, the supervisors had mixed views; some thought that BScN graduates are able to provide better care to their patients because of their theoretical knowledge and skills, which include critical thinking, communication, and coordination of care with physicians; others thought, they have a carefree attitude in terms of their accountability. For example Saher stated:

> I feel that BScN graduates are able to take care of their patients in a better manner because they are able to understand things in a better manner, they are able to think critically, they are able to discuss the patients views and the patients issues with the physicians, with their colleagues, and with the nursing management in a proper way as compared to diploma nurses.

Mashal alluded to their professionalism:

> They are thorough professionals, except for a few people, but the majority of them are thorough professionals; they are dedicated towards their work and they always want to work hard and they try to give their best in regards to nursing care. So these are their general strengths.

Though Sana acknowledged that BScN graduates receive better academic coaching in their program than the diploma nurses do, she didn't see much difference in their performance in terms of direct patient care:

> If we talk, of course like they are better groomed academically as well as their skills are better than the diploma ones,…such as they can judge better the patients' care requirements because they get more exposure to different clinical settings during their four years program. So in that sense, they are better, otherwise on the unit, we do not find them much different than the diplomas.

On one hand, Madiha thought that BScN graduates are good at taking care of patients, but on the other hand, she disliked their carefree attitude toward being held responsible and accountable for their shortcomings:

> I think they are making good efforts to make patients comfortable and to make them satisfied. Moreover, in my unit everyday one to two patients have a cardiac arrest and they are the ones who take all the responsibilities and make the differences in the care. I got feedback from doctors that "your nurses are very competent" and whenever I got this feedback once a diploma nurse and twice a BScN was on duty, but the diploma nurse was an experienced one and the BScN nurses were not that experienced. So even with less experience there are some, who are able to manage well.
>
> They are not concerned with what observations you give them and with what you tell them. *Haan tu ho gaya na* [Yes, it happened; so what?] their attitude is like this. Usually you would expect that when somebody tells you about your mistake you would say "yes, next time I will be careful." For example, blood, if the blood transfusion went in 45 minutes instead of two hours, there is nothing for them to worry about. So their attitude is very different,… if they are administering medications and they haven't signed, and the supervisor tells them that "you have given a medication at 10:00 and its 11:30 now, and you haven't signed." Their response will be *Haan to busy hoon tu kya ho gaya? Kar letay hain* [I am busy, so what? It will be done], I mean, there is no seriousness besides the safety component [in patient care]. So that is more bothersome for us as a supervisor. I don't know why they are not developing this attitude, positive attitude towards responsibility and accountability in patient care.

Although Sairah acknowledged that BScNs have more theoretical knowledge, their sense of responsibility and accountability and their professional maturity are not as good as those of diploma nurses:

> I found diploma holders are more accountable and responsible with their actions. For example, if a medication error occurs, a diploma nurse would come and report it to the concerned person: however, this behavior lacks in some BScN graduates.

> We found more honesty and accountability in diplomas, but again I will not generalize this but I am just talking about those individuals with whom I have been interacting or I have come in contact with. So in terms of accountability, responsibility and professional maturity, I found it more in the diploma graduates than in the BScN graduates. They [BScNs] are hi fi-tech [theoretical rather than practical] individuals who know each and everything but integration in the patient care is missing.

***Ability to organize and prioritize work***. The supervisors had mixed feelings about the BScN graduates' ability to organize and prioritize their work. For example, Sairah commented, "I have seen in patient care areas that they perform their work much faster." Similarly, Moona considered the graduates "very fast and dynamic. They can easily prioritize their work, decide what needs to be done first. They are able to judge that." Nidah and Madiha shared similar views with Sairah. However, Meher observed that although BScN graduates are able to organize their work, "they lack flexibility." She elaborated:

> Actually, sometimes your prioritization and the patients' prioritization is not the same; however, we need to consider the patient priority, if the patient needs a bath before the breakfast then he needs that, even if you planned to do something else at that time, you need to change the priority according to the patients' need, so at time they find [the graduates] it difficult, they lack flexibility.

Sana felt that "there is not much difference between diploma and BScN graduates." Mashal had similar views, and explained:

> Considering their [the graduates] good theory background, I initially thought or anticipated that they should have or they would have very good organizing and prioritizing skills, but now I would say that it comes with time; it doesn't come with your academic qualification, it comes with experience. So, I don't think that there is much difference between diploma and BScN graduates; it all depends how passionate you are in patients care and how well you want to perform, so it is not related to what they have learned in their program; but it is how well they want to perform; so, it is a learned skills that comes with experience. Every new nurse even the post-RN BScN, find it difficult to prioritize their work and manage time, when initially they return to the bedside work. So it requires practice.

Saher concurred with Mashal's thoughts and commented on the BScN graduates' ability to organize their work in the role of a team leader:

> I guess this is a skill, sometimes you have to work on that before you reach it. Generally speaking, we need to help them initially before they get going. So usually we train them [in their role of a team leader]. They learn to use a "to do list" or a checklist, we have some inservice session for this purpose. It is for all the nurses whether BScNs or not, we give them very practical sessions. We have also developed a tool that assists them as a team leader—like what is to be done, and when to it is be done, and they are able to cope with that.

***Safe and ethical care.*** I received varied responses when I sought the supervisors' views on BScN graduates' ability to provide safe and ethical care. Although most of the supervisors considered them safe, they identified some issues with ethical care based on their personal interpretation of the term. In general, it appears that the graduates are good patient advocates; however, they could do better in terms of self-accountability, as the following excerpts reveal:

> Safe, yes, but ethical you know [remains silent for a while], they provide safe care, plus/minus you know, let me give you an example. I usually talk about basic things that's why I am giving you an example of basic care. If a patient says to you "I don't want to take a shower today," I think, the nurse should ask the patient why, maybe the patient has some concerns or fears that you can address or resolve, and then the patient may agree to have a shower. But simply saying that "the patient didn't want a shower, so I didn't do it," is not enough from my point of view, but this is what BScN graduates do, I think they need to make some efforts. If you ask the patient, and he says I have pain or my stitches will break, so you can always take care of such concerns, you can tell the patient that your stitches are not so delicate as well as that mobilization will rather help in healing. So if you make efforts, a patient may be convinced. If you don't make such efforts, I see it *kam chori* [finding an excuse], perhaps it is not ethical because you could help but you didn't. Although you may have proof that a patient refused, but you didn't do your efforts, that's my concern with them. I think they need help at the novice level—Like for three to six months, but after that they don't need any help, again it varies from person to person. (Meher)
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> Ethics include accountability—I don't think they are much prepared for that, like we could rate them 5 out of 10. I think they understand the ethical issues like I often see them asking questions—when a physicians write an order to switch off a patient ventilators, then they ask questions about the patient rights and the family rights, so, they ask questions and they act as patient advocate. Sometimes when they identify issues and bring it to the attention of physician and get involved in decision making—with positive outcomes, like sometime if the physicians had not realized something, and you explain it from the patient or the family perspective, then they understand the situation and they [physicians] respond positively. (Moona)

> They are very concerned about the ethical issues because they have an awareness about patients' rights. . . . So definitely if anybody does anything wrong, they are more assertive and vocal about that "this is not right, you have to do this." I can recall one or two such examples, like if residents want to perform a procedure, such as lumbar puncture, they don't allow doctors to prick the patient more than twice and they call their seniors [the consultant]. Once the residents argued with her [the graduate], but she took a stand and said that "I won't allow you, you call your senior" and the [resident] did it. So later, I discussed it in a unit meeting, and they [physicians] were supportive because that was a right thing to do. (Madiha)

Both Mashal and Saher asserted that, in general, the application of ethics in nursing practice at AKUH requires some attention:

> There are people who would try to do things at their convenience "this seems right to me so I can do it," so there are short cuts, and BScN graduates are not exempt from that. They know how to do it perfectly [laughs loudly], but they would still try to do it in another ways, because that is more convenient for them, though usually safety is not compromised but standards are sometime compromised, so again they need to be supervised and pressured that "see this is the way things should be done." I think there have been some incidents related to patient safety with BScN graduates as well, but the nature of these incidents involving BScN graduates was trivial compared with incidents involving diploma nurses. Considering the fact that how much a novice nurse should know, they know it, they are alert, they try to be responsive to what they are doing, so that approach is there, so safety is not a big issue here.
>
> As far as ethical care is concerned, I would say it is our tragedy! Although all of us are taught extensively about ethics of care, somehow ethics is not implemented in patient's area as such. When we discuss patient care, we tend to speak very loudly which can be easily heard by others in the unit as what is going on with this patient. Hence, the basic features of ethics like confidentiality is not respected, people discuss things openly, so such a basic element of ethic which should be incorporated, is missing in our care including the BScN graduates. And again that sensitization to ethical issues, again that is also missing probably because of the lack of awareness of what are ethical issues and what is just discrepancy or disagreement on certain patient care decisions, such as discontinuing the patient mechanical support, they cannot recognize what is an ethical issue, "they are talking about withdrawal of patient support, so they see this is an ethical issue." But they are not sensitive to ethical consideration in their practice. They need to focus on how to incorporate ethics in the actual patient care situations

Saher offered similar views:

> They are comparatively safer, I have usually observed their thinking in the patient's care, they think for whatever they are doing, but sometimes things which

> may happen unintentionally, that are errors or mistake, then their good part is that many of the times, they would come to inform you that you know this is something that happened, or I did that, now what do I do. So that is something, at least they are thinking critically and they are making themselves responsible for what has happened. So you know, they are dependable, plus it is a good role modeling as well. You know, of course we can make mistakes, everybody can mistakes, but then to reflect and report about it, that is something good. Again this is something which is not just for the BScN graduates, everybody who is working there [AKUH], they know that they have to be safe for the patients, so they try their level best to do that.
>
> For ethical care, there are times when I feel there are some gaps whether it happens intentionally or unintentionally. For example, we have patients of different ethnicity and /or religious background, so they have different values than us as Muslims. And many times we are not very mindful of the others values. It could be that we are not aware of it or we don't want to go for that because it's not our value, I am not sure! Recently, I had one patient in the unit where the patient' family wanted to perform some ceremonies and the nurse said "no," I am not sure whether she was a diploma or a BScN graduate. So sometimes they bluntly say "no or it's not allowed" without thinking that if it is not harming the patient, the family should be allowed to do whatever their religious values are. So this is something which I feel, we have to work more on, knowing in theory is not enough, we need to practice it, we need to reflect on that "what we do, is it right?"
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> . . . Another thing, if we have some dilemmas in patient care, the hospital has an ethics committee, so we should refer to that, but usually our nurses are not aware of that hospital ethics committee. They rely more on doctors, so I feel that we have to make sure that the nurses are educated to question themselves as well as others. It may also require some experience, but we should be aware of it.

While reflecting on the list of some specific competencies, Sairah responded, "I think they are safe and they provide ethical care to patients, no doubts in that." This response was confusing for me because earlier at another point Sairah had stated, "If medication error occurs, a diploma nurse would come and report to the concerned person. However, this behavior lacks in some BScN graduates." Upon my request for clarification, Sairah responded, "I think that could not be generalized. That could be confined to a few individuals, and that cannot be generalized."

Unlike others, Sana responded that she sees no difference between diploma and BScN nurses and that both require equal supervision for safe practice.

***Interest in patient care***. Many supervisors including Meher, Nidah, and Sana charged that, usually BScNs are not interested to work at the bedside as staff nurses, but aspire to work in leadership positions, such as clinical nurse teachers or as a head nurses. For example, Sana shared:

> In my experience what I have been seeing for the last few years is that BScNs are not really as interested in patient care as in leadership skills. Not all of them. Of course there are different percentages of that, but in general they have this concept . . . that 60% would be interested in a management position and at least 40% would be there for patient care.

Meher also maintained that BScNs are not interested in physical care or hygiene care of the patients, such as giving a bed bath or a bedpan to the patient because they think of themselves as superior to other nurses. As a result, they shift their responsibility of patient care to nursing assistant without realizing that the ultimate responsibility of patient care lies with RNs and not their assistants:

> I think BScN graduates have hi fi [theoretical rather than practical] thoughts when they come over here [the hospital]. They are usually not willing to do the basic care of patients, but they are more interested in doing the medication, and the TL [team leader] work, they want to make a shift report or they want to set the break timings of the staff, and not the basic care. … I get the impression that they think of themselves as better than the diploma nurses, but like the post-RN BScN nurses. So they think that they will be soon promoted to a management position, but we find that their level is the same as the level of a diploma. I think they have to focus more on the physical care element of patient care. They need to realize that the element of basic care is the foundation of nursing. So first, they have to be proficient in their basic care, and then they can go further, like every newcomer, they need to go step by step and not jump. They have to be realistic about their progress.
>
> When it comes to answering the patients' call bells, they have problems because they know if they answer the call bell, the patient may ask for the bedpan, and this also happens that they might answer the call bell and then say to that patient "I will send you a nursing assistant," this is a usual complain from the patients. … No doubt we have nursing assistants who can help them [nurses] but all in all, it is the RN's responsibility, you have to guide the nursing assistant to do this, but you are responsible because you are legally responsible and the nursing assistant is not, he/she is not writing any nursing notes. Whatever is done, it is the RN' responsibility. You are accountable for their work…. So you have to be more attentive and strict and see what that person is doing. You have to be assertive enough that you get the work done without making the other person upset, and remain accountable to your supervisor. So you have to be tactful in your communication while delegating.

Considering Meher's concern that "BScNs are not keen in the physical care element of patient care," I asked some of the other supervisors and graduates to share their experiences or views on this issue. They expressed various perspectives. Some supervisors and graduates had not faced this issue; some thought that it is a general issue in nursing, but not specific to BScN graduates; and other graduates, particularly from the first cohort, as well as some of the male graduates confirmed the problem. Similarly, the respondents presented various opinions on nurses' work image and workload. For example, one supervisor from a critical care unit said, "I didn't find that in my area; I didn't see any reluctance or hesitancy in doing that [physical care]." Another graduate agreed:

> On my unit and there are three BScNs working with me. I think [reflecting as she speaks] all four of us have no problems in doing the care. We have never said no, I mean no one has complained about us that we don't want to learn or we are not willing to do certain tasks. We do work anywhere; we've never asked our TLs or head nurse to change our assignment.

Another supervisor in a critical care unit also refuted Meher's observation and provided some analysis of this matter:

> I have not found these observations or these problems in the graduates which I received [critical care unit], probably because of the challenging environment. . . . I haven't found them saying that I won't do sponge, I won't change the patients' position or their beddings because these are menial tasks, they have been participating in every component of patient care whether it is a complex task or a basic care requirement.
>
> Probably, this maybe an issue in [non critical care units] where nurses are mainly doing basic nursing care tasks, bed making, hygienic care, IV cannula care, and medication administration. I think that generic BScNs have probably — a different vision; they want to do things differently or they have a different perspective of care, I think, they want to do detail or in depth care which they have been taught in their professional education, they want to perform things in that manner or apply what they have learned which probably they are not getting enough time to do it in the general units. In our [unit name] because they are getting the opportunity for everything, we don't have this issue with them.

The above speculation corroborates some of the graduates' feelings that they were doing only "robotic work" without any opportunity to think and reflect (as Aisha and Kanwal detailed in their description of their workload). A supervisor in a general ward also supported this view. In addition, she explained that although basic care is somewhat of an issue on her unit, it is a general issue and not specific to the BScN graduates:

> Basic care, such as giving a bedpan, most of the time patient complains to me that your nurse said "It's not my job." . . . [However], it is not specific to BScNs, whenever we get new nurses, we get this complain. Then we train them, we tell them that this is her/his job, and nobody can refuse patient's care. Then with time some improve, some don't and definitely we take our steps and make them work. . . .
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> Many of them [staff] say, "there are many things in nursing that I have learned but I am not able to apply because 80% of my time is spend on changing or hygiene care. So I feel like what is the use of all that learning?" These are the frustration for nurses because I supervise them and I see them most of the time they are doing these things. So most of the staff, 90% of the staff is doing that… I always share with them that when we were at the bedside, we were doing this thing with pride, I mean we were not taking this thing as a burden. I remember we were giving four to five sponges very quickly and that was the time when you developed a relationship with the patients… That's what I had experienced in my life, in my bedside nursing, but I think the activity level is high now a days that's why they are very frustrated….10 or 9 years back, that was a very different scenario, we had a lot of senior staff but it is a different scenarios now, .those times were very different, I used to work with 10 to 15 seniors, but [at present] they [staff] are working with nurses of 1 to 2 years experience. This is the situation in our major units right now. So I think it is a different situation because when we had more experienced nurses, we had a lot of support from them, plus the acuity patients has also changed, so there is a difference. So definitely this is an area where we have to see; what are the constraints of our staff nurses at the bedside and how we can help them out. I have also suggested to my manager that we need to hire more assistants for this purpose.

One graduate who had worked in critical care also pointed out that doing basic care is not an issue in critical care units, but is on the general units, mainly because of the workload:

> I never had problems with that but on [unit name] we had one to one [nurse to patient ratio] or probably two to one, so we had only one or two patients to consider. If you talk about the general units where nurses are expected to care for 10 or 20 patients, and if we expect the nurse to give 10 or 20 patients hygiene care naturally that is a daunting task and anyone whether a nurse or a NA [nursing assistant] would have certain hesitation when it comes to that. I cannot do that if I am realistic. I cannot say about the present supervisors, when they were bed side nurses 10-15 years back, what kind of census they had in that point of time, how many patients they had to look after, but they must also consider the present situation that we always have full census and nurses are overburden with other responsibilities. Performing hygiene care is not that difficult as I mentioned

> before, but giving hygiene care to 15 patients besides other tasks is a tremendous task!

However, some graduates acknowledged that they had issues with giving basic care. For example, a graduate from the first cohort recalled:

> When we graduated you know, our impression was that after six months or one year, we would be offered a post, and I know some of my colleagues shared that they had difficulty in doing basic skills, because they were thinking that they will be prepared for a post, same as the graduates of post-RN BScN program, as they always get offered a post. We had this impression because we were also BScN students, so we thought; it will be the same for us. There were one or two people in our class who sincerely wanted to be a nurse, the rest of them came with a mind that after completion of the program they will be hired on a post, and they won't be doing basic skills in the hospital. We thought whatever clinicals we have in the program is more than enough to be hired on an administrative post. So it was very difficult for us. So most of my classmates got scattered, they went for higher studies so that they could get a post, they had very little experience in bedside nursing.

The above excerpt clearly indicates giving basic care is a status issue for some nurses. Hence, it is not difficult to understand that nurses might avoid doing tasks that they do not feel comfortable in performing. Moreover, apparently society does not value those who provide basic care, as noted in the following excerpt from a male graduate:

> In a hospital where we used to go as students for our clinicals, people [patients and their family members] used to say *AKU si nehlani wali aaga* [the bather has come from AKU]. …One day I gave a sponge bath to a patient, at the end of the shift that patient offered me ten Pakistani rupees. This is the problem you know, after giving basic care, people asks about your education, they feel pity for you, they think perhaps you are not so educated, therefore, you end up cleaning others. How long will you keep explaining this to people? It is very difficult to go for bedside nursing in Pakistan.

Another graduate agreed that it is a general issue, but felt that it is exaggerated when BScNs are involved:

> When a patient asks for a bedpan, I don't delegate that to another person. I do it. In general, I do see that some people avoid handling bedpans; I have seen that in some of BScN students also. However, it is important to note that BScNs are labeled for this attitude. So if two people of the diploma program exhibit such behavior and one from the BScN program, chances are the latter will be exaggerated, because BScNs were previously labeled for that.

Overall, the various perspectives of the graduates and the supervisors revealed that offering basic care might be more of an issue for nurses who work on the general ward than for those who work in the critical care areas.

### *Challenges*

This category consists of challenges that BScN graduates face in their work environment at AKUH as well as the challenges that the Nursing Management faces in dealing with BScN graduates.

#### *Challenges for the BScN Graduates*

The supervisors identified various personal and environmental factors that in their views are challenging for BScN graduates, such as, staffing shortage and management, workload, lack of monetary reward and slow career growth. Sana thought there seems to be a misperception from BScNs as to what management expect from them:

> They may be feeling that we have more expectations from them because they are BScN graduates, . . . so they should be knowing every thing, which may not be very true for them, "we should not forget that they are not the post-RN BScN and they have no prior work experience in the units," they are also novice like diplomas nurses. But of course if they are labeled as BScN, they might be feeling that we have more expectations from them.

Meher reckoned that BScNs have difficulty in coping with the workload:

> The challenges they usually face is the difference between what they learn and what they see. In theory they learn the ideal situation whereas when they come here, they are sometimes confused. I think in their learning phase they don't have the experience of taking full responsibility for their patients in their clinicals, so it is hard for them to cope with the workload [as a staff nurse].

However, like Mashal and Saher, Madiha acknowledged that the management sometimes asks many of the BScN graduates to work as team leaders, which she thought is a challenging responsibility considering the demands of patient care and staff management, particularly when the hospital is so short staffed:

> I think when we make them work as team leaders, it is a challenge for them because managing patients and managing staffing are the big challenges now a days because we have a lot of staff shortage. Plus working with the non-AKU-SON and novice nurses is also a big challenge. Coping with the physicians and facing them is also a challenge. When we [management staff] are not there, they

> are the one to communicate with them, they are solving the patient's problem. So I think these are all the challenges.

Although Nidah alluded to the challenges of patient care, she was more critical of the mismatch between the graduates' expectations and the existing realities of the work environment at AKUH.

> Like if you see so you will not find many BScN graduates working at the services side because there are a lot of challenges for working at the service side, such as staffing shortage. If you are working in the hospital, you are not doing the duty for 8.5 hours only but you are working beyond that. It is just like, you know, you are on your toes 24 hours a day.
>
> They have very idealized thinking, they want an ideal system and they find it difficult to work with limited resources and at times it becomes problematic for them in building a relationship with the supervisors because they expect lots of things from the management. they need this, this, and this, but the manager cannot get it. So at times I feel, although you know that they have good skills and what they are saying is also right, but resources are not there. If you have limited resources so you have to work with those limited resources. But they would say, "There are lots of things that we want to launch, we want to practice lots of things but we can't do that because of the limited resources."

In view of the above narrative, I asked Nidah what kind of resources she was referring to, and she replied:

> First of all staffing, we are short of staff. Similarly, material resources, such as teaching learning facilities, plus in terms of money also. Like they [Nursing Administration] want us to do lots of things, but we can't because its out of budget, So there, they feel a bit de-motivated.

It is worth noting that the supervisors' views matched to a certain extent the graduates' views with regard to the challenges of staffing shortages and the high workload at AKUH.

***Challenges for Management***

Some supervisors also reflected on the challenges that nursing management faces because of the BScN nurses in their work force. For example, Saher responded differently than other supervisors when I asked her, "What are the challenges of BScN graduates?" She detailed the challenges of nursing management in dealing with BScN graduates rather than the graduates' challenges. Saher complained that BScN graduates are demanding, they desire change and faster career advancement, and they have difficulty in accepting criticism from management:

> I am not sure about their challenges, of course as a novice nurse when they join the hospital, they would be going through the same anxieties and stresses as other novice nurses go through, but as a management person what I feel that it is difficult or challenging for us in management is to convince them [BScNs] for something that they [BScNs] want, they are more demanding as compared to the diplomas because they are able to think in a better way or in a more critical way. So it's like you know sometimes, in fact most of the time, I feel that they demand to work—in fixed shifts or in a leadership position, which is something not possible for the unit management. Sometimes, only after six months or one year of work, they say "we have enough in this unit and we want some change, or we want a transfer to another unit," and it is difficult for us because they are the strengths of the unit, if they are the ones always working as a team leader, it is not easy to transfer them to another unit. But it is difficult for us to convince them that "no, we need you here." They will not wait till one or two years which it is expected of them [to be promoted], its like they want everything to be done very fast, they want a change right now! . . .
>
> If they are good in things they want drastic career growth which is not possible because you have policies and those policies are actually the same for the diplomas as well as for the BScNs. So we just cannot take one person after six months time and promote them on the basis of their capabilities as compare to the diplomas who have been here since two years or three years, but they were not promoted for some reasons. So you know, in a way retention of those people is challenging for us.

Like Saher, Sairah also observed that BScN graduates expect to work mornings instead of on rotating shifts:

> They expect that they should be given morning shifts because they are seniors now, senior in terms of that they are BScNs, so they should work mornings, ...and there are family pressures too. Those who are married have family constraints. So most of the BScN prepared nurses do not like to work shift duties, which doesn't help because the patient needs are similar in all shifts. . We are trying to keep the BScN nurses in shift duties, we make sure that they are compensated for shift duties.

In view of Sairah's comments, I asked her, "Is there a special allowance for working evening and night shifts?" She replied:

> Not at present. It is not a regular practice, but it happens on an ad hock basis, suppose someone is willing to do more evening and night shifts instead of the rotating shifts of two mornings, two evenings, and two nights per week, then we compensate them through shift allowance. Yet, again it's started recently, it's not

> a regular feature but we are trying to make it a regular feature for all of all the staff [not only BScN graduates].

Nidah's views corroborated Saher's:

> In my opinion which is not necessarily correct, but they [BScNs] are position oriented and money oriented. They want to see themselves on a position and secondly they feel that their salary is not equivalent to post-RN BScN nurses. Their challenge is that they are a bit impatient. They want a career ladder, their career ladder has to be very fast and they want everything to be right which is not possible. They have to be you know a bit adjustable to the resource available or the practical situation. So in my view they are bit impatient and they are not tolerant.

Sana expressed similar views to those of the others and reported that BScN graduates threaten to resign when management is unable to comply with their demands:

> It is difficult to handle them, like there are individuals which are difficult to handle. As I said before they expect to work on a post or something like that. So it is difficult for us because we treat them as a staff nurse and want them to work at the bedside with the better skills and competency, but from their perspective, they should not be doing the bedside nursing, they should be somewhere in a senior position. So there is a conflict between the management and them. We find them difficult, even in terms of communication sometimes. They compare themselves with diplomas: "We have more education than diplomas." . . . We see all of them equal but they see it differently, so this causes the problem, like they compare themselves and this comparison is difficult for us because our expectation from them and their patient care assignment are the same for all staff nurses. So it's difficult to handle them on a one to one basis sometimes.
>
> There was one situation where one of my staff said that I should be the team leader because I am a BScN; otherwise, I will resign, and in our view one of my diploma nurses was more competent and had better skills to handle the unit than a BScN. One more issue is that they want to work in specific areas. They think that they shouldn't be assigned in the area in which they don't want to work. So at the time of assignment, they threaten us that if we are not going to assign them in that area, they will not continue. And they do not, they do resign and leave. So there is a pressure from them, they can't work for the institution needs, but their own preference.

Although from a different perspective, Sairah alluded to an important factor that many graduates also viewed as a source of tension between the graduates and the supervisors:

> Most of the managers are post-RN BScN here [AKUH] and now we have many nurses from the BScN Program [working as at the bedside]. So nurses at the bedside and in management are at the same level in regards to their professional education…we need to enhance our knowledge and skills and performance to a higher level because those who work at the bedside look up to their leaders as role models. So we need to progress, otherwise I think the management group will remain far behind from the graduates, and managers and bedside nurses will become equal. . . . So the management group has to make progress.

It is important to note that another supervisor, Saher, also pointed out the issue of interpersonal relationships between the graduates and their supervisors. However, unlike Sairah, Saher recommended that supervisors be tactful in dealing with BScN graduates.

### *Attrition and Retention of BScN Graduates*

This category consists of the informants' narratives concerning attrition and retention of BScN graduates. Almost all the supervisors referred to the retention of BScN graduates in their interview, and of the eight, five supervisors commented on this issue in response to the grand-tour question. Although the supervisors had varied reactions to and speculated on this issue, they concluded that BScN graduates are generally not committed to working at the bedside. For example, Madiha responded:

> I think now a days, more of them prefer to go abroad than be here [work in AKUH], so it may impact their attitude. They start to prepare for going abroad while they are at AKU-SON, they do their exam like IELTS … they themselves have shared this with me that they have done their exam in year three and now they need some experience, because 1 to 1.5 year experience is a must, so they have to work, there is no choice for them. Otherwise, they are not bothered about money I think.

Saher pointed out that unlike diploma graduates, BScN graduates have more opportunities for a faster career growth, so it is difficult to retain them in direct patient care services:

> What I see is that they [BScNs] have more opportunities for work. For the diploma nurses it is mandatory in a way that everybody has to work at the bedside first and then they can go for their post-RN BScN because they need at least two years of experience. … [However], for the BScN graduates, they have the opportunity to work in CHS [community health sciences], to work as a faculty, work as a research assistant, or enroll in a masters program directly because they don't need any experience for those programs. … They are not willing to work as a bedside nurse in the unit because they feel you know we may confine their

> growth or they will be stuck there. So sometimes what happens is that many of the graduates join areas which are independent, for example, the research office or something else, and from there they can come out very easily and they can go for their masters or something like that. So you know it is very difficult for us to retain them as well in the unit, first of all because of their own willingness and then because they have more opportunity to go anywhere since they have of course good knowledge, good skills and good qualifications. So they usually kind of try to escape and go and they don't like to continue as bedside nurses.

Sairah wondered if perhaps BScN graduates have a different philosophy of nursing, because she found them different than diploma graduates in regards to their enthusiasm and commitment to patient care. She speculated two reasons for their high turn over rate in the hospital: their aspiration to continue in higher education and their desire for better monetary rewards because they have spent more money than the diploma graduates have on their education:

> I don't know whether their [BScN graduates] preparation is different or what, but diploma nurses are more committed, more concerned, more empathetic and more enthusiastic for patient care, BScN graduates seems to have their own philosophy—what I have observed—they come, they work here for a year and then they leave. Even today I got two resignations from the graduates who had joined last year (2005) and it's not a year that they resigned, they joined in September or October and this is June 2006. So if you calculate, its nine months only and they want to leave for a Master degree as they have stated in their application. I think their philosophy is to get education at a faster pace than diploma graduates—and as a professional I think this is right! They have done their BScN, and now they want to go for their Masters, and then they will go for their Ph.D. … I have been observing the same pattern for the last five years, none of them has left the institution for marriages, none of them have left the institution for going abroad, but everybody who has left us, just for the higher education, and diplomas, yes their education planning process is much more slower than BScNs. So maybe their philosophy is different for higher education.
>
> Once, I was taking a class, when a post-RN BScN student questioned me about why the earlier graduates of AKU-SON were very committed and compassionate for the institution as compare to now a days? So we brain stormed the causes and what we came out with [speculated] was that earlier scholarships were given to the students—the university helped them for their education and [in return] the graduates [diploma nurses] considered it their moral responsibility to support the institution by working here—versus graduates [BScNs] of today who have to pay for their education, and many of them take loans for their education. . So they have a different vision [goal], they have other commitments, if they paid for their education so they have to earn back to pay for their loans and support their families. So there are some differences, and the tuition fees for BScN graduates is higher than diploma, so maybe that's a factor too!

It is interesting to note that, in general, the supervisors' reasons for poor retention of BScN nurses in AKUH were validated by some of the informants in graduate category. For example, Arzu, a secondary informant commented:

> Maybe they don't get the opportunity to use their intellect and abilities when they are assigned in the general units, they are only doing routine work, like to insert the drip and to give and take over, physical tasks, though this is also part of the work, but definitely you need some challenge, some sparks to recharge your brain, maybe they don't get that, and that's why they leave. Nevertheless, the common reasons are salary, promotions and other stuffs, such as career ladder, work environment, and increased workload.

However, Bilal offered further explanation about the retention of graduates at AKUH particularly of the male graduates:

> The general perception at AKUH is that BScN graduates hardly stay here, I question do you give them incentives to stay here, if you offer a person let's say on average Rs.10,000 per month and lets say another hospitals is offering Rs.20000, where do you think the person will go? He will definitely leave to another organization with better prospects, so once again people complain that we do not have any people who are experienced. I think we had people who were more experienced, but then instead of giving them incentives to stay back and retaining them, we lost them to other places. We hardly have graduates particularly males from the four-year BScN program over here, and the main reason is that we are not offering them enough incentives, nurses are going towards the West, the U.K., Australia, the U.S., and Canada, why? Because they are being paid better over there, they have more autonomy, and they have more self respect. Unless we create a healthy work environment for nurses, you can't expect them to stay here, if they don't stay here they will not get that experience. And for the boys [male graduates], they have no role models, so they say "why shall we stay here, let's go out, we need to study more, and we need to do something else." …. In Pakistani society where the males are considered as the bread earners and the females are considered as the support to the bread earners, so the guys are expected to makes most of the money and the females work to support whatever the gaps are, so I guess that is another reason why the attrition of male graduates is higher than for females. And then of course it also has to do with male ego. Guys do not like being ordered around, just taking a wild guess, females are more subservient, so they may not object so strongly to this work environment, it has more to do with our Pakistani society.

In addition to Bilal's comments about the BScN graduates' salary at AKUH and other organizations in Pakistan, I learned from other graduates that some disparities also exist within the various constituencies of AKU. For example, three female graduates with a similar academic caliber from the class of 2002 began to work in AKUH at Rs.7700/month as their initial salary. Within the next two years, two of the three left AKUH while one continued to work there. In May 2006, even though all three of them were working on a teaching position, their monthly salaries differed greatly. Of these three graduates, the one who was working in a non-AKU organization had the highest salary, that is Rs.18000, the one who was working in AKU-SON was earning Rs.16000, and one who continued to work at AKUH was paid the lowest, that Rs.12000.

Overall two themes traversed the supervisors' narratives as illustrated above under various categories and subcategories of information: expectations, and differentiation and association. Whether consciously or subconsciously, the supervisors revealed high expectations of the BScN graduates due to their association with degree prepared nurses. While sharing their views about the competence of BScN graduates, the supervisors always saw them in comparison with diploma nurses. They differentiated BScN nurses from diploma prepared nurses with both positive and negative connotations. Moreover, the supervisors described BScN graduates somewhat a distinct group nurses based on their specific characteristic, such as confidence, assertiveness, and progressiveness in regards to higher education.

### ***Summary***

The supervisors' narratives indicated a distinct difference in the theoretical knowledge of BScN and diploma graduates. The supervisors concurred that BScN graduates have sound knowledge and that it influences their confidence as well as their performance in terms of judgment, reasoning, and decision making. Most of the supervisors characterized the BScN graduates as confident, vocal, and assertive. They identified various reasons for their acquiring such characteristics, including sound professional knowledge and their family and schooling background. On one hand, the supervisors viewed the assertiveness of BScN graduates as helpful in communicating and collaborating with the members of the health care team; on the other hand, they considered this assertiveness as a hindrance in their interpersonal relationships with members of the nursing team, particularly with their supervisors.

Most of the supervisors appreciated the BScN graduates' contribution to teaching/learning activities. They also reflected positively on the potential of the graduates to assume leadership roles, particularly as team leaders; however, they agreed that they need some coaching and mentoring to reach their potential. Unlike the graduates' teaching and leadership contributions, supervisors indicated that their potential for research, even at the implementation level, was not realized because of a lack of initiative and workload. Likewise, the supervisors felt that the graduates have the abilities to contribute more in terms of patient care, but they had mixed views on their actual contributions. A number of supervisors contended that BScN graduates are not committed to or interested in working as bedside nurses, but aspire to leadership positions. However, it also appears from their narratives that the graduates, particularly those in the first cohort had some misconceptions about their role in nursing services. The supervisors also commented that retention of BScN graduates at AKUH is a challenging issue for nursing management. They speculated about various factors for this lack of retention, including the challenges of nurses' work environment at AKUH and the career development opportunities for BScN graduates outside AKUH.

## Effect of BScN Graduates on Patient Care Delivery

To identify the effect of BScN graduates on patient care, I asked all of the informants, "How do BScNs graduates contribute to the delivery of patient care?" Some supervisors found it difficult to respond to this question because they considered it vague; therefore, I tried to elaborate on the question by asking, "Do you see any impact of BScN graduates on patient care, or is there anything that indicates that BScNs make a difference in the delivery of patient care?" In response, some supervisors reflected on the association between the graduates' knowledge and skills and their ability to make patient-care decisions or their productivity in providing patient-care services.

Sana reflected:

> I think their contribution is quite good because I do have staff on my units who are very much interested in patient care. They utilize their skills of patient teaching and all of what they have learned in their program, and there are a few of them who are very good. I can say that those people would be the ones who could be the leading forces on my unit.

Sairah suggested that one can differentiate between BScN and diploma graduates at the bedside once they have completed the transition period:

> For the first six months to one year their contribution is similar to the diploma graduates because it is the transition phase or adjustment period. But if you ask me about experienced BScN graduates who have been in the system for the last two to three years, yes, they do make a difference in terms of patients' education and patient-care decisions, such as fluid management and medication administration. They even make treatment suggestions to the consultant in terms of drug regimes. A consultant may or may not take this suggestion, but there are some who consider their suggestions, not just in terms of medication administration, but for the patient care as a whole, and that's where you see the difference.

Saher reflected on the graduates' reasoning and critical-thinking ability and their confidence in communicating with members of the health care team:

> The way they care for their patients at the bedside, they are critical enough to think about the patient's safety, to think about patients' needs and treatment plans. Plus their communication skills with the support services and with the physicians is something which I feel is good for the reason that they have the confidence to talk with them, to challenge practices, to question themselves: "What is it, and why are we doing this?" So that is something which is again a contribution to patient care.

Meher elaborated on the advantage of graduates' knowledge and rational thinking:

> They have broad and rational thinking when they do things; they can justify why they did or did not do this. They are better in theory than diploma graduates . . . . For example, if I ask them why this patient has an ineffective breathing pattern or what measures are being taken and why, they are able to answer. So because of their knowledge, they can assess things promptly and take action. Generally, they think better, and the general impression is that they want to work with critical patients [high acuity] more than stable patients.

Nidah substantiated Meher's views and described various characteristics of BScN graduates that help them to adjust faster in critical care areas:

> As far as I have encountered the BScN graduates, most of them are good at the bedside; they perform well compared to the diploma graduates because they learn fast. Their critical thinking is very good, so their practices are rationalized . . . . As a supervisor, I feel it's easy to teach the BScN graduates. They understand the concepts quickly; they acclimatize fast to the unit. Though it is quite normal for novice nurses to get nervous in caring for very unstable patients [on a critical care unit], generic graduates are composed; they are confident; they don't lose themselves quickly; they try hard to learn things, accommodate things, and adjust to the system, so that makes a big difference.

Moona's views coincided with those of Meher and Nidah, and she alluded to graduates' promptness in responding to critical situations:

> Because their knowledge and assessment skills are good and they are confident, it helps them to prevent complications in patients' care management. For example, if a patient is received from the OR [operating room] in unstable condition or with compromised airways or poor oxygen saturation, then I see that they take over the situation quickly and they start doing airway management. So I find them quick in problem-solving skills.

Although Madiha did not have much to say because of the limited number of BScN graduates on her unit, she reported that the graduates adapt fast to the critical care areas:

> Again, it is very difficult for me to respond to this question because I have very few BScN graduates; two of them are assigned to the Special Care Unit. So I think, to a certain extent, they adapt faster than others, but individual differences are there because some diplomas are also very good.

Mashal thought that, in general, the overall productivity of BScNs is better than that of diploma nurses:

> When we receive new graduates, we often say, "This is a BScN graduate, and this is a diploma graduate"; but at the end of year, if I look back and see who are the best staff on the unit, I see more than fifty percent of the best staff are the BScN graduates, so probably the purpose of the BScN program has been achieved.

I would also like to make point that, although the BScN program is meant to improve patient care and not to produce leaders or first-line management initially, for some reason the graduates of the program perceived things differently at first. I recall a few graduates from the first cohort who thought that they would work a little in the beginning, and then they would have a management position. But when they began to work in the actual role of a staff nurse, they realized, "We still need to learn a lot; we still need to work a lot." And after that they began to improve, and they worked towards it.

So if I look around now, almost all the BScN graduates are team leaders after completing their first year, whereas diploma graduates are taking a longer time because of their communication skills, leadership qualities, and the theory background, which I expect them to posses in order to have a team leader role. So they [BScN graduates] are the backbone of our unit in regard to productivity. Definitely, they need some facilitation in the beginning as novice nurses, but once the first six months are past, they will be very good, and one can observe that, yes, they are BScN graduates, because their speed of learning and adjusting to the environment is much quicker than a diploma. So you can see their productivity sooner, which is not very evident for a diploma graduate—although at times you may see such productivity in some of the diploma graduates, but at a lesser ratio: If it is eighty/twenty for a BScN, it would be twenty/eighty for a diploma, so it is almost a reverse ratio.

### *Summary*

In general, all of the supervisors were cognizant of the contribution of BScN graduates to patient-care services in terms of quality and productivity. The supervisors reflected on various abilities of the graduates, such as knowledge, promptness and rationality in patient care decisions as well as their confidence in communication with other members of the health care team. Moreover, they acknowledged that BScN graduates were fast in their adaptation to the work environment that consequently yielded better productivity.

## Expectations and Preparedness of BScN Graduates

I asked all of the informants in the supervisor category about their expectations of BScN graduates and their methods of communicating these expectations to the graduates, as well as to share their perception of how well BScN graduates are prepared for what is expected of them in the nursing services at AKUH. The purpose of these questions was to elicit the degree of correspondence between the professional preparation of BScN graduates and their expected roles and responsibilities in nursing services. The informants' responses are detailed below in three categories: expectations of BScN graduates, ways to communicate expectations, and preparedness versus expectations.

### *Expectations of BScN Graduates*

Some of the supervisors made a general comment that they expect better performance from BScN nurses, and others alluded to specific elements of their competence. They discussed different competencies required in patient care, such as good theoretical knowledge, critical thinking and problem solving, psychomotor skills, vigilance, and astuteness in providing safe care. In addition, they highlighted a number of professional/ethical characteristics such as regularity in attendance, honesty, empathy, and sensitivity to patient care. The supervisors differed in whether, immediately after graduation, they have the same or different expectations of BScN graduates compared with diploma graduates; however, all of them expected a better performance from BScN graduates after three to six months of experience.

Moona made a general comment: "From a BScN graduate, I expect good knowledge, good communication skills, and good management qualities like problem-solving skills and decision-making skills." Meher delineated the importance of attendance, which she expects from all nurses, including BScNs. In addition she expects quality and accountability in patient care:

> They [BScNs] should have a realistic approach to life—should be more reflective and cognizant of small things that may matter in the quality of patient care. They should be more astute and try to see the world from patients' perspectives in order to provide services that satisfy their patients. They should take full responsibility for managing patient care . . . . I want the result that, whatever is assigned to you, if you have not done it, there should be a good rationale for it, and not, "I was busy" or "Someone else didn't do this" or "He/she didn't tell me that." I won't accept such answers: "If you can't do something because it is not possible and you need any help, tell me then. Office work is my least priority. I will leave everything and work with you if you need my help." So I want accountability. Sometimes staff try to cover each other, and this shouldn't happen.

Sana and Madiha reported that, initially, they have the same expectations of BScN graduates and of diploma graduates:

> We expect, they should be competent and skillful to handle patient care and should have all the basic skills of a nurse. And, of course, once we feel that they are groomed at that level and are able to handle the unit situations independently, then we expect they should become team leaders and progress in their career. But initially, of course, we feel that they should work at the bedside level and meet the needs of the institution. (Sana)

For new nurses, initially, we have the same expectations whether they are from the diploma or the BScN program. We don't give them very different expectations, but definitely if they have done their electives here, then we tell them, "You can work even independently because you have had exposure to the unit and the staff." Otherwise, initially, we give them the same expectations as diploma graduates. However, after three months, definitely we expect them to perform better than diploma graduates. (Madiha)

In contrast, Mashal revealed that her expectations of BScN graduates are always higher, particularly in regards to their knowledge and self-directedness. Moreover, she pointed out that BScN graduates themselves expect to be treated like adult learners and are eager to work independently:

> I believe, whether that is intentionally or unintentionally, we have more expectations from BScNs, even though the theory part or clinical part that is covered in their curriculum is not very the different from diploma program. But again, they are expected to perform at different or better levels compared to diplomas. That is somehow at the back of my mind whenever I receive a new BScN graduate: I assume that they will be good in their knowledge base, and thus will do things better, and I will need little effort to make them function as staff nurses. So I expect that they should have a very good theory background and self-directedness because their curriculum focuses more on self-directed learning compared to the diploma program. So my approach to BScN graduates becomes very different than to diplomas, because I expect them to be more self-directed, I expect them to understand things on their own and then come up with the problems or concepts that require discussion . . . . In general, I expect all the qualities that are required for becoming a successful nurse and effective in nursing practice, those qualities should be there in the BScNs graduates.
>
> What I have experienced is that BScN graduates would say that they would prefer to be treated like adult learners, and they prefer to work independently in patient care. They don't want to be followed or watched all the times. Initially, for 15 or 20 days, I buddy them with senior staff of the unit, but they always ask me "when I am going to work independently?." However, it depends on the individuals, how confident and enthusiastic they are for their new role in professional life.

Saher's primary expectations of BScN graduates are that they will be "safe clinicians" and perform well in other areas, including teaching and leadership:

> A nurse has to be safe whether she is a diploma or BScN graduate. And for safety, of course they have to think critically about everything they do. In general, I feel we expect more from a BScN nurse than a diploma nurse—first, safety in patient care and then good performance in other areas, such as teaching and mentoring. In addition, if they are assigned as a team leader, of course my expectations are that they should be perfect in doing their tasks and follow the standard practice; they should follow the instructions that are given to them.

However, Sairah expected professional maturity from the BScN graduates, and she wanted them to play a more active role in the physicians' rounds because, in her view, BScN graduates have sound knowledge and should feel empowered by their knowledge:

> Professional maturity, and they should demonstrate sound clinical knowledge, such as, when physicians are making rounds, physiotherapists are making rounds, they should participate and speak with confidence. Doesn't matter, the first or second time they may not be right, but many times they are well-groomed individuals, and they can participate in things. They should not stand there and just observe what is happening around them; they should also participate. The reason I am saying this is that most of the time when a physician comes for a round with a group of residents and others, my nurses just stand there and listen to the conversation; however, nurses are the ones who are there all the time, and they know exactly what is happening but somehow they are hesitant to participate. I don't know why—maybe due to cultural barriers as nursing is a predominantly female profession.

When I asked Sairah whether the lack of participation in the physicians' rounds is a specific problem for BScN graduates, she replied, "No, no, it's a general concern. But I expect the BScN graduates to be more vigilant and more confident at the bedside compared to the diploma graduates because they possess sound knowledge, and in my view knowledge is power." Sairah also reported that nursing management currently has the same expectations of BScN and diploma graduates, but she reckoned that "it needs to change" because she felt that BScN graduates are prepared better than diploma graduates:

When they join as a fresh graduate, either a BScN or a diploma nurse, we treat them equally. I've said earlier that they possess very sound knowledge such as physiology and drug knowledge, they have more courses such as biostatistics and other things in their curriculum, but in the units we treat them equally. So we need to change that and have higher expectations of them because I think BScNs are better prepared individuals.

Nidah added, "I expect them to be patient, to be motivated, to be learning fast and getting into the system fast and be more sensitive towards patient care and their families." I asked Nidah to elaborate on sensitivity:

> We are running short of staff, so there is a high workload and stress on every individual who is working in this system. The more you go up the ladder, the higher the stress level, so everybody is stressed out. Many times with this stress and workload you overlook being sensitive towards patient care; many times you

> just focus on documentation. You are asked to do double quite frequently. Definitely, if you are asked to do double duties on a daily basis, many times you neglect so many things that matter in patient care. For example, if you are doing double duty and you have a very busy shift, sometimes while changing a patient's gown or examining a patient, you miss or forget to draw the curtains. Or if you are looking after a female patient, usually we tie their buttons loose so that it's easy for them to reopen them, and sometimes the buttons are not tied properly and the patient's shirt is not fixed as it should be. We don't realize these things. Although it's a very important thing, you are too busy doing other things, you have a high workload, you are very stressed, a consultant is standing over you, the head nurse is also checking your documentation and other things, the patient's haemodynamic is fluctuating, so sometimes we lose this sensitivity. Therefore we should be more sensitive towards patient care.

### *Ways to Communicate Expectations*

The supervisors affirmed that, initially, they communicate their expectations to the staff nurses, including the BScNs, on their first day of the unit orientation. For example, Mashal said, "Usually the first day is the orientation day on the unit. We have a slot for sharing expectations both from the CNI and the head nurse and from the employees as well." Likewise, Nidah stated:

> Usually we conduct a unit-based orientation. It depends on how fast the new staff can grasp [the information], how much time we have, how quickly we want them to be working independently, all these factors, but usually for a week or one and a half weeks we have unit orientation. So during that time we also tell them about our expectations.

Madiha described the process of competency-based orientation (CBO) in communicating the management's expectations to the staff:

> On day one we meet them [new staff] to discuss the competency-based orientation checklist, or CBO. So we tell them about our expectations of them and [ask them] if they have any questions or concerns. We tell them that they have to complete the CBO in a month's time with a senior nurse or the clinical nurse instructor. This helps them to know the unit routines, team members, and the existing policies and procedures on the unit. We also tell them about the leave policy, attendance record, duty roster, and other such things; and then we tell them our expectations of doing double duties. They are buddied for fifteen days with the clinical nurse instructor, she explains to them the unit routines, medication administration, IV cannulation, and how we work here, how do we do things, such as handling of patient complaints. First we assign them to the general unit. We observe them continuously—whether they are working well—then we assign them to this special care unit. We tell them, "You will have very sick patients

> there, and you will be working with one NA, so you have to be very careful in terms of critical thinking, problem solving, approaching the physicians, making rounds with them, and patient family education," and things like that.

I then asked Madiha to elaborate on the expectations of working double shifts:

> Double duty basically means that if the staff has some emergency [personal reasons] or there are city crises and they cannot come, then the staff on duty is expected to do a double shift. But definitely their concerns and their problems will be heard. It is on needs basis, but you have to be prepared for it. We tell them that every nurse will have a turn; it could be once per month or twice per month. But if we have one person absent per week, then they have to do double once a week.

I inquired how the staff are compensated for their double duty, and Madiha explained:

> Definitely, we do pay them, but nowadays nobody is interested in payment; they want time off. We offer them overtime, but most of the time they want [a day] off, usually the very next day. But sometimes if it not possible, and they will say, "Okay, I work on Thursday; will you accommodate me for that day?" So we see what is feasible for us and them, and that's what we do.

It is appropriate to mention that although Maidha's response corroborates the existing overtime policy at AKUH, the staff have somewhat different perceptions of the payment of overtime. For example, some graduates reported in their interviews that at times they do not get payment or time off for overtime. A conversation with the unit staff during my participant observation helped me understand the apparently conflicting information about compensation for overtime:

> While I was conversing with a staff nurse, other staff members on the evening shift kept coming to the lounge. Zubair looked at Rohina as she entered the lounge and said, "I thought you were not coming in today." Rohina responded, "I should have called in sick; there is no point asking for a leave. I called to ask for time off, but they [management] refused. So I couldn't call sick today because I had already told them the truth that I need to attend a birthday party. I requested that they at least change my shift from evening to morning so I could have attended the party. It is a matter of my relationship with my in-laws." Rohina also commented, "I will see how they will ask me next time to do a double. We do double duties when management ask us, but what do they do for us?" Other colleagues in the lounge began to sympathize with Rohina as she expressed her dissatisfaction with the management. I asked one of the staff, "Are you paid for overtime?" One of them responded affirmatively, while the others said "No." So I responded, "I am confused: Is it yes or no? I am getting a mixed message." Plus the policy of overtime clearly states that one should be either given time off or

> paid double for working beyond three hours over the expected hours in a week." Zubair chuckled and said, "Let me tell you clearly that the management doesn't want to see their overtime hours going beyond a certain figure, the Head Nurse is expected to control her budget, therefore she also prefers to give us time off, but when it is not possible, then they only offer to pay us. However, the system of paying overtime is not very straightforward. *Appko HN ki pass ckukker laganai partai hain* [You have to constantly follow up with the head nurse]; it is not an automatic system. So it is better to ask for a shift off in lieu of overtime rather than waiting for an overtime payment that may or may not be processed. (PO, June 24, 2007)

The supervisors identified a number of others ways, in addition to clarifying their expectations during the unit orientation, of communicating with their staff and reinforcing their expectations, such as having conversations during the shift overlap time, during the head nurse's and clinical nurse teacher's unit rounds, and in inservice teaching sessions, staff meetings, and one-to-one feedback sessions, as appropriate. For example, Moona reported:

> In my unit we have one-to-one meetings in which we spend time with the nurses and we tell them our expectations. We also have staff meetings in which I verbalize and point out what is happening on the unit and what we need to focus on. So sometimes we do individual meetings, and sometimes we discuss matters as a group.

Similarly, Madiha stated that, besides during the orientation, there are other ways in which she has the opportunity to communicate or reinforce her expectations to her staff:

> We usually meet with the staff in the morning and in the afternoon before their shifts begin. I go to the lounge in the hand-over time; I try at least three times per week. We share our concerns, I ask them if they have any concerns, or I tell them things based on my rounds or observations regarding patients' care. I also get to hear things from the shift supervisors. So I think that is one way. Second, we have monthly meetings; and third, my office is on the unit, and whenever they want to approach me, they can come and discuss things with me freely. Likewise, I call them for an individual meeting when necessary.

Meher revealed that she uses both direct and indirect ways to communicate her expectations to the staff:

> The interaction between the staff and myself is very frequent, not only because I am there during the shift-over [shift change], but also when I do the patient round or unit round. I check their stuff like their documentation, [and] I usually stick a

> note on their patients' files indicating what is not done and that they need to complete it as soon as possible. When I do a patients' round, I expect that things should be completed.
>
> In the patient round, usually the concerned nurse accompanies me. We talk about things related to patient care, so I tell them if something needs to be done. Sometimes I also convey my messages indirectly. For example, on the round I ask things from the patients: "Have you had your shower today? Did you have your hair washed?" If they did not have their hair washed, then I ask them, "When was it done last?" So in this way the staff also realize that they haven't done something that they should have done. Usually after such conversations with a patient, the staff will say to me, "Sorry I hadn't asked the patient or haven't done this, but I will do it now.

### *Preparedness Versus Expectations*

Most of the supervisors expressed their satisfaction with the BScN graduates' theoretical knowledge and other cognitive skills, but they thought that the graduates could have better psychomotor skills. Some supervisors indicated that the graduates have difficulty coping with the required workload in the hospital, and they reckoned that, although BScNs are fast learners, initially, they need assistance with integrating their theory into practice. They also pointed out that BScNs need to improve in certain aspects of communication and interpersonal relationships. Moreover, they commented on the attitude of the BScNs in terms of flexibility, commitment, and accountability for patient care.

Meher complained that the graduates are prepared to work in an ideal situation and that they have difficulty in adapting to different situations:

> Actually, they have difficulty in improvisation of patient care. It is difficult for them to modify the ideal situations that they have learned in school into a practical form. They see things as black and white; they need to learn that at times things are grey. For example, when we work in the community, we use a cloth instead of a screen because we don't have a screen for patients. So when they have learned such things in the community [community health nursing], why can't we apply that in AKUH? Sure, we have to be conscious of the quality, but we also have to see the time limits when thinking of the ideal. However, we should also not take shortcuts; if things are available, then we have to do it. So if I have to rate them on a scale of one to ten, I will say six out of ten.

Moona also alluded to the graduates' performance in their initial period of adjustment; she acknowledged that their theory is good, but not their psychomotor skills:

> They have good knowledge, but skills-wise, they are not so good. But it is the same with the diploma program also: When they start working as staff nurses, they have the theory, but they need practice in the patient care areas. So it is the same with the BScN graduates, that they have knowledge, but implementation is required in patient care areas.

I asked Moona, "How would you rate the graduates on a scale of one to ten?" She replied, "For knowledge, six to seven; but for skills, one out of ten. But once they learn their skills, then they are fully prepared." Saher had similar views to those of Moona, and she further elaborated on the graduates' lack of psychomotor skills, offering examples of specific skills. In addition, she commented on the emotional stability of graduates in dealing with a specific type of patient population:

> I feel that there are two components, the theory and the skills. When they come as fresh graduates, their anxieties are the same as diploma nurses, but their theory is better than them. But for the skills, generally speaking, sometimes they are not that competent, and sometimes they are not able to cope with the skills or with the number of patients that are being given to them. So that is something that I feel they need to work on more. For example, IV or blood transfusions or reflocheck [a test for blood sugar], these are very basic skills, but sometimes we need to train them for these skills as well. So then you think that in four years' time, if they are not able to take this as a nurse, how can we expect them to care for patients independently? Their level of skills as novice nurses is actually the same as the diplomas.' So I feel we need to do something regarding that, so when they come to the hospital, at least they would be able to work a bit more than the diplomas from the skills-competency point of view, which means their psychomotor skills. I feel that they need to have more exposure in their student lives to psychomotor skills.
>
> One more thing: emotional stability—I mean, the ability to take care of personal emotions and patient emotions. For example, we have patients who are depressed, such as oncology patients, who are not mentally positive for themselves; they have low self-esteem. So I feel that BScN graduates should be better prepared for such scenarios. We need to incorporate some exercises in their preparation that could give them confidence to deal with those kinds of patients as well as to deal with their own feelings apart from their patients' feelings. This kind of emotional preparation is something that needs to be done in the school because there is nobody to mentor them here if they are not confident by themselves. So, generally speaking, in the nurses we have this shortcoming. So if the graduates have such skills, then they could help themselves, the other nurses, and then you work for the patients. So I guess the satisfaction level would go much higher than what we have now.

I asked Saher whether she had ever extended the probationary period of a BScN graduate because of his or her skills:

> Only one person. Her confirmation was deferred due to her attitude, mainly a problem with her attendance, but not because of her knowledge or skills. We identified what she was required to improve, and then she worked on it. With ongoing feedback and attention, she improved.

Mashal believed that BScN graduates are well prepared as general nurses, but not as specialized nurses, and the expectation is that they should be able to work in specialized areas. Nevertheless, she noted that most of them are able to work independently after about three months of facilitation on the unit:

> Considering the general requirements of nursing, I believe they are well prepared for basic tasks and basic responsibilities, but not for specialized-care areas, though some degree of facilitation or mentorship is required for every one, whether one is master's prepared or BScN prepared or diploma prepared. But we expect a lot more from generic BScNs.
>
> Now, when we receive them, we know that they are equipped to work, but they are yet not able to work independently at the bedside; they know everything but need practice. So we work with them, and then within two or three months, the same staff are handling patients independently. These are the same graduates who were students three month ago, so if we had placed them in a similar situation during their program, then they would be ready to wok upon joining the unit. On the unit we don't teach them much of the theory, but they do perform basic things in these three months, which seems to be sufficient to prepare them to work in critical care areas. So I guess some kind of change is required in the existing clinical model of the program because preparing them to work independently is very different from doing things independently.
>
> I would like to make a point here that I have hardly ever deferred BScN graduates after three months. Most of them, or ninety percent of BScN graduates, are confirmed after their three-month probationary period. The ratio of staff deferment has been higher in the case of diploma nurses, so I would say that BScN graduates are prepared well, they have learned well, and they respond well to the expectations of them because of their knowledge and skills that they acquired in their program.

Although Mashal acknowledged that it is probably unrealistic to expect that BScN graduates be prepared to work in specialized areas, this is what AKUH requires. In her view, this can be remedied with certain modifications to the program. For example, towards the end of the program students should have more hands-on experience in specialized areas where they may work. I will further elaborate on this point later in the section on suggestions for curriculum improvement. Mashal also referred to three areas where the graduates could be better prepared: psychomotor skills, communication in sensitive situations, and sense of responsibility and ownership for patients:

> Our graduates are very good in theory concepts but they lag a little behind in the practicum that nurses should have in order to take care of a patient. Nurses have to be skillful in their psychomotor skills to overcome their fear of working independently at the bedside. In other hospitals the nurses are good in their skills. They would never hesitate in patient care and say, "I haven't done this or that," even if they are borderline in their [knowledge of] theory concepts.
>
> Dealing with routine situations is probably not difficult for them, but dealing with difficult situations like a patient or family in the grieving process, patients or family who are crying about an impending loss or actual loss [is more difficult]. So dealing with such emotional situations in which more sensitive nursing is required, they are usually inexperienced or probably not well equipped to handle those situation. No doubt they are good in communication, but when it comes to sensitive types of communication, they often lag behind.
>
> What is happening now is that during their clinicals, most of the time they are overshadowed by their faculty. And when the faculty is not around, the student may say, "We will do this when our faculty comes," and they won't do things, when the faculty is not there. It is not an issue with all of them, but some of them, because, as I said earlier, they are usually self-directed learners. But a sense of responsibility towards patient care—"This is my patient, I am his nurse, and I am accountable for him"—is not there because throughout the four-year program such ownership is not being developed because they will always say, "inform the RN; inform the doctor." So this sense of ownership and level of ease with patient care is missing somewhere in people. Therefore we take a lot of time to train them, and the whole three-month probationary period is utilized to make them work independently. If this kind of facilitation is done within the program, then they would come here and they would work like anything.

Like Mashal, Maher also contended that some change is required in the current way that students are supervised in clinicals, because in the existing system students spend very little on clinicals and do not have the opportunity to feel ownership of the care of their patients. She offered specific recommendations to address this problem, which I will describe later in the section on suggestions for curriculum improvement.

Sairah suggested that most nurses, including BScN graduates, do not participate in the physicians' rounds, but are very quiet. From Sairah's perspective, BScN graduates should play a stronger role as clinicians because they have sound knowledge. Similarly, she expected that patients would benefit from the better education of BScN graduates, but lamented that this is not the case to a large extent because most of them leave the hospital within one year:

> We expect that the nurse-physician collaboration will be good based on their scientific knowledge, because knowledge is the area where they could prove themselves as clinicians with the other clinicians. And second, we have higher expectations of BScNs in terms of patient care. We think that our patients should benefit from them because they are better educated for patient care, but that doesn't happen now [appears upset].

Of the eight supervisors, four, including Sana, Madiha, Saher, and Nidah, pointed out that, in general, BScN graduates are well prepared, but that, apparently, some are not very committed to patient care, to the profession, and/or to the AKUH. Sana commented:

> I think they are prepared for the basic skills. From the clinical point of view and other things, they are okay; but I think, again, they need to know that they are prepared for bedside nursing or patient care. Wherever they work later, bedside nursing is part of their profession, and they should accept that. In their academic preparation it should be explained to them that they should not have high expectations as entry-level nurses on the unit.

Similarly, Madiha considered BScN graduates not very enthusiastic or committed to bedside nursing in the hospital as nurses were in the past. She identified some possible reasons for their lack of commitment and dedication to patient care:

> Generally speaking, I think they are well prepared for bedside work, but it's a general comment. We used to be very enthusiastic when we began to work as staff nurses; we were available all the time. But I think BScN graduates have more commitments other than their work; they have other commitments too. They have to go to the library or prepare for different exams such as post-graduation or International English Language Tests [IELTs]. So they have to go as soon as they finish their work because they are tired; they are doing morning duty on the unit, and they are attending classes in the evening, so they have a different attitude towards the job. I think they are not fully devoted to their job; they have other things to do during their job time and after duty time. Then they have other family responsibilities as well, so they are not available for a single minute. So in regards to work or skills, they are prepared, but we are unable to see that devotion. What I mean is that, along with their official duties, they are also involved in meeting some personal goals, so there are the limitations in their work . . . . If I recall my experience, when I was at the bedside, I was fully [devoted to] the bedside. I didn't go anywhere other than work or prayers. But it's not like that nowadays; it's very different. I mean, their lives are tough. In general, they prepare for going abroad rather than staying here [to work at AKUH], so there is an impact on their commitment, their job, and their performance.

Saher posited that some BScN graduates join nursing not because they are committed to the profession, but because they can use their qualifications as a stepping stone to achieve other goals, such as migration to other countries:

> I feel that they need to be more sensitive as graduates, I guess. They need to know the limitations of the profession and be committed. I feel that we need to somehow increase their insight for the profession because I am not sure why people enter this profession. Generally speaking, a few of the graduates give me the impression that they were forced to come into this profession, maybe because of finances, or many times I feel that they want to go abroad. And, of course, after a BScN there is a demand outside, in the US, in the UK and all. So I feel that sometimes it's not their choice of career to work as a nurse here, but they want to do it just so their qualifications can help them with the immigration process. This is something that is, I feel, kind of selfishness and not a committed professional. After their graduation they should work for at least one to two years. Just a few return to the university. I think they should have this kind of insight into their moral responsibility.

Unlike Madiha or Saher, Nidah did not believe that graduates lack commitment or dedication, but she emphasized that they have to be very committed and dedicated to AKU to cope with the workload and stress they find in nursing services or the hospital:

> I think they are ninety percent prepared for what is expected of them in the nursing workforce. Yes, most of the time they are ninety percent prepared, but I think the workload and the stress that we have in our nursing services is enormous. And if BScN graduates don't have enough sensitivity and dedication towards the organization [AKU] or to the profession, or if they are money oriented, then it is difficult to retain them.
>
> If you are dedicated to the organization, if you know what your motive is, if you know that you are here for patient care or you are working here for your self-growth and learning along with patient care, then you can work here. If you really want to give something to your unit and you are also aware that your unit will suffer if you leave, then you may continue working here. But if your motive is not so strong, if you expect that, along with your motive, you must get good pay, a good reputation, and respect, then you may not survive here for long. These are not unfair demands—all are fair demands—that you get a good salary according to your work, you get a good reputation, and people talk to you in a respectful manner. However, our institution has some shortcomings. There are so many people from our unit who have resigned because they were not given enough money here, which was definitely a very important factor for them. If your whole family is dependent on you, then the motives that I stated above will not be important, and you will be working for materialistic gains.

### *Summary*

Overall, supervisors expect BScN-prepared nurses to have good knowledge, skills, and attitudes. Some were more explicit than others in identifying their expectation of better performance from BScN graduates than from diploma graduates. They expect BScNs to perform better in direct patient care as well as in terms of teaching and leadership activities. Although all of the supervisors seemed satisfied with the knowledge and other cognitive skills of BScN graduates, they identified issues with their psychomotor skills as well as their attitudes toward patient care or the profession. With some exceptions, most of the supervisors related the high turnover rate of BScN-prepared nurses to a lack of commitment to AKUH or the profession. However, Nidah referred to the shortcomings of the institution in retaining nurses.

## Utilization of BScN Graduates

I asked all of the informants, "Are BScN graduates being fully utilized?" In response, only one responded affirmatively; the rest gave reasons for their opinion that they are not being fully utilized. A number of informants related the less than optimal utilization of graduates to turnover; however, they had different ideas on this relationship. Some of the informants suggested strategies to better utilize the BScN graduates. To illustrate their views, I present their accounts below.

When I asked Moona whether she thought that BScN graduates were being fully utilized, she asked whether I was inferring that they should be in management positions. Upon clarification, she replied, "Yes, I think they are" without elaboration. To the contrary, Nidah responded swiftly:

> No, for full utilization it's necessary that you provide them opportunities in whatever capacities they are working, make the system favorable for them, and teach them things that need to learn, if you do so, you could utilize them better. I mean, many times the environment is not favorable for them or their suggestions are not readily accepted. For example, if a BScN graduate is working at a bedside and she is also interested to teach in the school, I mean the opportunity to work as a joint faculty, they don't get it, usually such opportunity is reserved for people in the administrative position, head nurses or managers, and most of them are post-RN BScN nurses. So BScNs are not given the opportunity or they are not facilitated for improvement. . . . In terms of research initiatives, most of the times, it is limited to nurse managers or the Director level, but I think it is not

> compulsory to involve only the nurse managers, the head nurses, or the CNTs, bedside side nurses may also participate in research.

Madiha replied, "I think their career ladder is a little bit delayed because, at present generally in the hospital, we have more post-RN BScN positions than BScNs." I asked Madiha, "Are you saying that there are not enough opportunities for them?" and she said, "No, there are enough opportunities, but maybe their [the graduates'] aims are different. They go for a master's quickly, or they are in the process of immigration, and that's why they are not getting the opportunities." Similarly, Sairah reckoned that graduates were not being fully utilized because of their high turnover rate at AKUH:

> They leave us within one year. . . . However if they stay with us for more than a year or two years, I can see their abilities, but we don't get many chances to observe that because hardly one out of 10 BScNs that I have on board has more than two years of experience and she is also planning to leave for her master's in the coming year.

It is important to note that although Sairah mentioned that she had only one BScN graduate with more than two years of experience, when I was seeking to find BScN graduates in June 2006, it was identified that she had five BScN nurses with more than two years of experience and another five with more than one year of experience.

Like Sairah, Mashal also pointed out that the average number of a BScN graduate's years of service at AKUH is one to two, and she related the high turnover rate to the less than optimum utilization of the graduates. She proposed that they may be bonded for a certain period to offer compulsory services to the institution. It is a common practice in Pakistan for nurses to be bonded by their alma mater to provide two to three years of service to their associated hospitals. However, Mashal was cognizant of the ethical implications of bonding graduates. Therefore, she asserted that the issue of turnover among BScN nurses deserves detailed exploration:

> It requires proper research as to why retention is an issue with the BScN graduates, whether it is working expectations, whether their own expectation that the institution is unable to meet, whether it is the salary package, which is creating a problem, whether it is, what they expect or what they ought to get, but are not getting. I guess separate research should be done focusing on the retention of this particular group, and then it may work out as to how they may be utilized properly. So we may utilize this group in a better way, as this group has a lot of

> potential….In regards to whether the graduates are good or bad, that I think happens in every program whether it is diploma, BScN or MScN, or whatever. But we need to examine why it is happening rather than just saying that this is our issue.

Some informants thought that the graduates are well utilized in the direct patient-care areas; however, they contended that they could participate more in other areas; that is, in teaching and research. For example, Sana replied:

> At the staff level, yes, they are well utilized, but maybe… they don't have a chance to show [their entire potential] because we are not offering them a role which they may be expecting from us. …Right now we are utilizing them at the bedside level or at a team leader level, not more than that, but I would also say that if we … want somebody for our CNT or Head Nurse position, we do count on post- RN BScNs or BScNs rather than diplomas. The graduates may be better utilized in area of research, teaching, or administration, once they are able to prove themselves, like everyone else.

In addition, Sana pointed out that at times nursing managers are unable to fulfill the expectations of the BScN graduates in terms of salary or position. She had met an ex-graduate from 2004 who had worked with her for six months, and Sana asked him whether he would like to come back. He responded, "If you give me a good package and position." Sana inquired about his salary as a faculty member at his current location, and she learned that it was almost double the salary that AKUH would offer him. She said, "I couldn't offer him this salary or a position."

Mashal believed that, apart from bedside nursing, BScN graduates might be better utilized by participating in research-related activities, and she proposed some strategies:

> In critical care areas, they are fully utilized for what they are expected to do, except for research….I guess there should be some way to involve BScN nurses in research related activities, like we have for the management group. Whatever area the may have come from, we should bring all the BScN graduates together at least once in a quarter or once in a year and let them highlight the areas where they could be involved, we provide them facilitation or mentorship to participate in research, but unfortunately… at present we are working under very stressful conditions, we are short of staff in almost all the months… so in that [situation] poor them [the graduates] they are doing double duties, and doing other things at the bedside, so even if they want to do it, they do not have enough energy to do that. In addition, participation in research could be incorporated in the evaluation criteria of the graduates. However, before creating such expectations, the graduates must have some opportunities to do so.

Like Mashal, Meher also thought that graduates could not be expected to participate in research unless opportunities were available: "I don't expect that from them right now, but I would like to see their involvement in research. If they come with initiative, I would love to help them out."

Unlike others, Saher responded, "Some of them are underutilized and some are overutilized." To support her assertion, Saher gave an example of a BScN graduate, Zobia, who had been working on her unit. Zobia had worked a year at the bedside and wished to upgrade her education. After some negotiation with the management, Zobia enrolled in a master's program in addition to working part time on the unit. Yet her work was commendable. Considering her abilities and the dire staffing needs on the unit, Zobia was given additional responsibilities, and she was able to manage that well. Saher explained:

> Zobia was actually overutilized, she was aware of her skills and her capabilities, but she didn't misused it, she utilized it, she fully contributed in patients care, and today everybody recognizes her contribution. . . . But contrary to Zobia's situation, there are others who are working at the bedside for two to three years who may also have such capabilities [as Zobia], but because of the lack of opportunities, or because of some other factors, they are there at the bedside only. So I think, they are underutilized because as a generic [BScN graduate], I feel they should progress upward in two years time, at least to another position [more than the staff nurse]. …Some of the imbalances in our system are responsible for under or over utilization of the graduates, such as employees' inter-units transfers and promotions. So some change is necessary in this regard; however, I guess its not one or two [people] who will make a change; it has to be a system change.

### *Summary*

In general, the supervisors suggested that perhaps BScN graduates have the potential to engage in a variety of nursing roles besides the role of staff nurses, but they were not being utilized fully. The supervisors offered various reasons for the less than optimum utilization, including structural and organizational realties. At least half of the supervisors acknowledged that there is a need for nursing management to examine and address the factors that prevent maximum utilization of BScN graduates.

## Perceptions of the BScN Program

To identify their perceptions of the BScN program, I asked all of the informants two questions: "If you were to advise a young person who wants to join nursing, would you suggest that person to take the BScN program?" and "Is the diploma program adequate for general nursing care?" Most of the supervisors answered these questions affirmatively and supported their responses. I present their account in two categories: advice about the BScN program and adequacy of the diploma program.

### *Advice About the BScN Program*

With a few exceptions, the supervisors appreciated the BScN program because they thought that BScN graduates have better knowledge and skills than diploma graduates do. Although all of the supervisors acknowledged that a BScN degree for entry to practice in nursing is a faster route for professional development, two were of the opinion that perhaps it is better to begin with a diploma, followed by a degree. However, Saher indicated that, although she prefers a BScN, not everyone will qualify for acceptance into the program, so they can begin with a diploma program and take the degree program later:

> Yes, I will advise for the BScN program compared with the diploma program, but my suggestion would be that they apply for both programs. If you qualify for the BScN program, that's good, but if you don't, then at least you can go for a diploma and work later for a degree. You don't waste time, and you do what you can, but my preference is, of course, the BScN program.

Meher reflected on her personal experience and explained why she prefers the BScN over the diploma program:

> They are better equipped with communication skills, plus they are prepared with a broader perspective on care. They are prepared with better potential for patient care; however, utilization of their potential varies for individuals. . . . I am a diploma nurse, and I want to do a BScN [post-RN] because I know that after a BScN degree I will be more skilled, such as in regards to research or teaching, how to give an effective presentation or express my ideas more effectively. BScNs learn some advanced concepts for patient care that also count. I did the health assessment course as a special student because it is not taught in the diploma program. Because I work with BScN nurses, I thought that at least I should be better prepared to supervise them.

Nidah's experience corroborated Meher's views:

> You go through a process in which you explore yourself. The program helps you to capitalize on your hidden abilities; your abilities are developed or polished, and you acquire some new abilities as well. So you become a very different individual when you complete the program. As a BScN graduate you gain confidence, you improve your knowledge, you become vocal, and there are many things that you learn besides your professional knowledge.

Madiha also commented positively, considering the timeframe and outcome of the BScN program:

> I would definitely advise her/him to go for a BScN degree because I have seen differences in the outcomes of these programs. Plus the time period involving these programs varies. I mean, if you do a diploma first, then you need a minimum of two years' experience before you can be enrolled for a post-RN BScN, which also needs another two years of your time. So instead of spending seven years, you could spend four years to obtain your degree.

Mashal's response substantiated Madiha's comments:

> I would suggest that they go for a BScN for various reasons. One, considering my experience with BScN graduates, they are more mature and better equipped professionals, so I would definitely suggest the BScN program. Two, it saves you probably three years of time in your career. It takes you longer to obtain a degree after the diploma versus if you begin with a BScN. And considering our cultural context where marriage at a young age is preferred for girls, it is better to begin with the BScN and be able to spend that time on other things, whether you want clinical experience or to upgrade your education like doing a master's or whatever you may want to do. In fact, I would suggest that we should stop offering the diploma program and only focus on producing BScN graduates.

When I asked Sana the same question as others in regards to advising other about the BScN program, she kept quiet for few seconds with a meaningful expression on her face. Therefore, I assured Sana that I was interested in her honest views whatever they might be, she then expressed:

> In terms of exposure and experience, I would prefer a diploma nurse because with diploma nursing you first work on your basic skills and then before the post-RN BScN, you require experience. If you do your bachelor's after having had some experience, I think you are in a better position to understand things, and you can set your goals accordingly. So I think a post-RN BScN is much better than a BScN because BScN graduates probably don't have extensive exposure to patient care [at the bedside] that really helps you in higher education.

This indicates that Sana favoured higher education for nurses; however, she preferred the diploma program as entry to practice in nursing to a BScN degree.

Although Sairah held similar views to Sana's in regard to the value of experience as well as professional education, she also thought that the BScN program would be preferable considering the fast pace of life these days:

> Of course, yes, because it saves time. For example, it took me seven years to get a BScN degree, so it saves you time if you begin with a BScN degree. But there are consequences to that as well. When you do a diploma followed by a post-RN BScN, you spend at least seven years in the same profession. I mean, first you complete a diploma, then you implement your knowledge, you identify your knowledge gaps, and then you come back for further studies. That's good in a way; you learn more, and you learn things practically because you get more clinical experience. However, I also think, considering today's fast pace of life, you need to move fast, so it is more feasible for the younger generation to begin with a BScN degree.

### *Adequacy of the Diploma Program*

All of the supervisors agreed that, apart from individual differences, graduates of the diploma program are adequately prepared for general nursing care. However, many of them alluded to the additional capabilities of BScN nurses that they considered important for nurses' professional development and image.

Sana commented that although the diploma program may be adequate initially, continuous professional education is a necessity for nurses' career advancement:

It could be that the benefits of a specific program vary from one individual to another. However, in today's world, continuous education should be part of your professional life, and having only a diploma will not be sufficient to grow in your career.

Meher and Moon reflected on their personal experiences and considered the diploma program sufficient for bedside nursing. Although they highlighted the value of learning through experience in nursing, they also pointed out the advantages of a degree program. Meher stated:

> Yes, a diploma program is okay. . . . Let's take my example. Many of my BScN colleagues are not working as head nurses; they were not promoted to the head nurse position. So I think it also depends on the person as to how you utilize your experience. . . . Though I think one is more confident after a BScN because you get a broader exposure to various things and learn how to speak professionally,

> which you don't get to learn, or I didn't learn while doing my diploma, but I have learned many things through my work experience.

Likewise, Moona replied:

> It is adequate. You can't say it is inadequate; it is adequate. For myself, initially, I did a diploma, and I never had difficulty in terms of patient care before doing my post-RN BScN. I also worked in a management position, and after my degree I am continuing in that position. However, it is good to have a BScN because it prepares you at a better level, with in-depth knowledge. You get to learn more with a BScN, such as teaching and research subjects, which helps you when you are involved in the delivery of patient care.

Saher commented that although diploma-prepared nurses have sufficient knowledge and skills for routine bedside nursing, they need more assistance in the patient care areas. Moreover, their leadership qualities, including confidence and critical thinking, are not as good as those of BScN nurses, which may affect patient care:

> If we consider their [diploma graduates'] theory and skills for bedside nursing, then, yes, though they need more assistance [compared with BScNs] when they begin to work as a staff nurse. We need to mentor them more appropriately, and after three to six months time they are able to cope with the expectations. So for patient care I feel diploma nurses are okay. However, their leadership qualities are not that good; they are not that positive towards themselves or confident, and they are passive. Likewise, although they are good for routine care, they have to perform certain procedures or do medications; sometimes they don't question things or are not critical in their thinking as BScN nurses are, which has implications for patient care.

Sairah thought that not only are diploma graduates good at bedside nursing, but they also have some good leadership skills in patient care areas. However, she felt that BScN nurses enhance nurses' image in regard to clinical knowledge:

> Their competencies and skills are adequate, they are professionally well groomed, and we can always see that in our clinical setting. I have found that diploma graduates are also excellent team leaders compared to BScN nurses. Nevertheless, we need to make progress in terms of nurses' clinical knowledge; we should be at par with other health care professionals. I think BScN prepared nurses would enhance our professional image in terms of clinical knowledge. I think professional soundness comes with higher education: The more you learn, the more you do; the more you do, the more you benefit your patients. However, it is difficult to see the envisaged impact of BScN nurses if they don't stay in the

> clinical areas. At present, they stay with us for barely a year; almost every BScN nurse leaves AKUH within a year.

Nidah affirmed the adequacy of diploma prepared nurses for bedside nursing. However, she alluded to the importance of BScN prepared nurses to enhance the professional identity of nurses:

> Many times they are capable enough to take care of patients. They have lots of potential, but they are not so polished in terms of their confidence or communication skills. But there are many diploma graduates who are very good and who are better than some of the degree nurses. So for general nursing, yes, the diploma program is sufficient. However, if we aim to improve the image of nurses or want to give nurses a professional identity, then it is necessary that nurses have better knowledge and communication abilities. And definitely BScN prepared nurses are more confident, they are more vocal, and they have better articulation. They can hold discussions with other members of the health care team, but usually diploma nurses cannot, even if they know things. Many of them have good knowledge, but they have no confidence or they are shy. I mean, they are kind of covert [timid in their approach].

Madiha also responded positively about the adequacy of the diploma program for general nursing care, but she preferred the BScN program because it offers the possibility of faster professional development:

> I think, yes, but for a faster professional development the BScN program is more appropriate, provided that you qualify for it. Not everybody is eligible for the BScN program because it requires a minimum of intermediate qualifications, and overall it is harder than the diploma program. But if you can get in, then it is the faster route; you can go for your master's after two years of experience. As a professional, I think that a BScN nurse with two years of experience seems better than a diploma nurse with the same years of experience who will then go for a post-RN BScN. BScN graduates are better because they begin with sound knowledge, and hence they are confident in their practice compared with diploma graduates, who begin with limited knowledge and communication skills. So they are not very assertive. Therefore, I prefer the BScN program.

Mashal saw no problem with the adequacy of the diploma program with regard to its curriculum; however, she suggested that nursing leaders must review the availability of the human resources required to cater to the needs of students in the diploma program who appear to be of a lower calibre than BScN students:

> I think the diploma program has every ingredient required for a nurse to practice safely. But I feel that the quality and maturity level of students that we have in the diploma program is an issue. Most of the time they are not from a science background, or their schooling background is not so good as it is in the case of BScN students. Therefore usually diploma nurses have difficulties grasping some of the complex concepts in clinical work. The curriculum for the diploma program is okay; the curriculum is fine. But probably these students require more facilitation, more supervision, and more mentorship during their three years of professional education, which is probably difficult considering the required ratio of faculty to cater to the particular needs of such students. Therefore we are having problems with the diploma program. It is not the curriculum, but other factors that are involved in the delivery of that curriculum. I am also a diploma graduate, and I know the aches and pains that we faced and experienced during our diploma program, and now we realize that if that had not happened to us, we wouldn't have been able to do what we can today. I suggest it is better to have a stronger foundation. If you don't have a stronger foundation to begin with, and later you do your BScN and master's, you still may not have the same professional impact as if you had to begin with a stronger foundation upon entry to nursing.
>
> I feel that if we continue with the diploma program, we need to pay attention to the process rather than the content, especially the faculty-to-student ratio in their clinical rotations. I am seeing nowadays that one faculty has ten to fifteen students or one faculty is covering two areas at a time, so for them these are unrealistic expectations. And then if we are talking about quality outcome, it won't happen because these diploma graduates are usually not very mature, they are usually not very self-directed, so they need more supervision considering their schooling background. You need to make more efforts to bring them to a certain level, which may be done if you have enough manpower, enough clinically experienced people who can assist this type of student. So I guess we need to pay attention to this area; otherwise, I don't see any issue with diploma-prepared nurses.

### *Summary*

In general, the supervisors' accounts reflect a fairly positive perception of the BScN program. They all recognized some advantages of the BScN program, including its faster route to professional development for nurses. Most of the supervisors alluded to the additional capabilities of BScN graduates compared with those of diploma graduates, such as sound knowledge and leadership skills. They all considered the diploma program adequate to prepare nurses for general nursing care; however, some indicated that the BScN program requires a better quality of candidates for enrolment in order to produce a better calibre of nurses with comparatively less effort on the part of nurse educators. With a few exceptions, the supervisors preferred the BScN program to the diploma program in preparing better qualified nurses for the improvement of patient care and increased professional identity of nurses.

## Suggestions for the BScN Program Improvement

Although some of the informants had already identified areas for improvement in the BScN program in their responses to other questions, I asked all of them two specific questions in this regard: "What suggestions do you have for the four-year BScN program in the future?" and "What changes would you recommend in the curriculum for the four-year BScN program?" One supervisor responded that the BScN curriculum is good and does not need to be changed, whereas the rest of the supervisors identified various areas for improvement. I present the informants' narratives in three categories: professional characteristics, communication/interpersonal skills, and curriculum and courses.

### *Professionalism*

This category comprises the informants' responses pertinent to the graduates' professional commitment, work ethics, and attitude towards bedside nursing. Six of the eight supervisors commented on the need for improvement in these areas. Meher discussed BScN nurses' attitude towards bedside nursing:

> One area is attitude toward bedside nursing. They should realize that initially they have to work at the bedside, if they perform well, then they can progress to the next level, such as team leader, and if they are not performing at a certain level as a bedside nurse, then they can't proceed to the next level or be promoted to the next level just because of their BScN degree. They should be able to reflect on their personal abilities and performance besides their professional education.

Sana also offered her opinion:

> I feel that they should know that they are prepared to work at a very grass root level or for direct patient care; a basic role of a nurse, the career ladder comes later. I think giving them this concept of directly getting in to a management position or making them feel that they are a bit superior to others is not appropriate. So this issue must be addressed somewhere in the program.

It is worth mentioning that Sana consistently showed her concern over this issue throughout her interview.

Madiha and Meher alluded to the graduates' sense of responsibility and accountability, which has implications for patient safety. Madiha noted:

I think they are well prepared, but as I discussed earlier about their sense of responsibility or accountability, it needs to be enhanced. They should be more concerned for patient safety and have better compliance with the existing policy and procedures; such as when administrating fluids or medication, this needs to be emphasized.

Similarly, Meher stated, "That carefree attitude, 'So what's wrong? It is not a big deal!' as I elaborated earlier, needs attention." It is important to note that, as mentioned in a previous section, some supervisors commented on the graduates' sense of responsibility and ownership for patient care with specific examples from their experience.

Saher suggested that the graduates must develop insights into professional commitment:

> They must develop an insight and commitment for the profession; this could be part of the emotional strengths needed by the professionals, or developing passion for the profession and may be developed through some reflective thinking. So they could feel more responsible towards the profession and towards the university. Though they should be able to exercise their rights, they should also know their obligations.

Mashal identified the need for sensitivity towards ethical considerations in practice:

> They are not sensitive to ethical consideration in their practice. It needs to be looked into as how to incorporate ethics in the actual patient care situations. No doubt, they are taught ethics in their curriculum as a separate subject. But it requires integration throughout their learning process in other courses. Hence, in every course, one needs to stress ethical consideration with equal intensity.

### *Communication/Interpersonal Skills*

This category presents the informants' suggestions on how BScN graduates can improve their communication and interpersonal skills. Although all of the supervisors had earlier shared their views in detail about these skills, Madiha and Moona reiterated their concerns and the need for improvement in these skills. Madiha said, "Their interpersonal skills need a little improvement"; and Moona advised, "They need to spend more time on communication skills and should be taught about the difference between assertiveness and aggressiveness, because I have often seen them fighting with other people. So they need to improve in this area." Mashal emphasized the need for graduates to enhance their communication abilities in dealing with sensitive situations:

> The communication skills which are taught in the program should incorporate dealing with difficult scenarios or sensitive situations. For example, how to deal with a dying or terminally ill patient and their family, and how to educate them or teach them. What is usually important for the patient family—the patient outcome, so how would you tell them this realistically?

### *The Curriculum and Courses*

This category consists of the informants' identification of gaps in the content and delivery of the curriculum as well as suggestions for improvement in specific areas of the curriculum, including the quality or sequencing of the content, both theoretical and practical.

Sairah made a general comment that BScN graduates usually rely on theoretical or idealistic knowledge, but they lack pragmatic knowledge. She emphasized the need for a curriculum that is more integrative or reality based:

> They [BScN graduates] should not always refer to the bookish solutions but to practical solutions. They should know more about the alternatives when the ideal facilities are not available. For example, if they don't have a very modern ice pack for the relief of a bruise, what else they can use. I suggest that their curriculum should be more integrated or reality based instead of very theoretical. We also need to enhance the cultural aspects of our society in the curriculum because most of the books that we are using are western, and most of the time, the literature that we use is not local or national. So we must find ways to know what is happening in the country aside from what is happening internationally. For example, most of our nurses don't know what is PNC and PNF [Pakistan Nursing Council, Pakistan Nurses Federation], or what are the top five diseases responsible for mortality rates in Pakistan.

Mashal commented on the need to strengthen the pharmacology course:

> Though the knowledge of pharmacology is very weak in diploma graduates, BScN graduates also have only marginal knowledge related to pharmacology, and they have difficulties in integrating the knowledge of pharmacology with patient's condition. At present, pharmacology is taught in the program as a non nursing subject, and it is a theory based course. So what is required—integration of pharmacological knowledge into clinical situations.

Madiha proposed some changes in the sequencing of the courses in the BScN program to improve graduates' ability to attend to their patients' basic care needs:

> When they come to the hospital, we are really surprised by them because they have difficulty in terms of patient basic care procedures [psychomotor skills], they say that "these basic things, we did it only in our first year," so I think, these things should have been focused through out the program. For example, I know we have very comprehensive policies and procedures for basic care skills that students are taught in the program, such as care of indwelling urinary catheter, you teach them in their first year. But I don't know whether these skills are reinforced in their succeeding years or not. As by the time, they come to us, they don't know how to give care for an indwelling urinary catheter. If you ask them "how frequently are you supposed to change the patient catheter, tubing and bag?" they give you varied answers. I think presently, in their last semester of the final year, concepts of research and management are reinforced. So maybe they forget the basic care procedures. I think, toward the end the program, basic patient care needs should be reinforced. Because maybe, the students retain whatever is taught last to them and other things are washed out that they learned earlier, or as they study more and more, their thinking gets so advanced that they forget the basics of nursing, and hence it is neglected. This is my perception.

Like Madiha, Mashal also commented on the sequencing of courses in the program in relation to the graduates' comfort and ability with their psychomotor skills as novice nurses:

> One of the important points is the sequencing of courses in the program, at present, probably is not appropriate because the major essence of nursing is medical/surgical courses, and medical/surgical courses are taught in year two, or I guess some of its component are also taught in year three, but the entire year four is spent on teaching leadership, research, and biostatistics, and so on. So the major portion of learning pertinent to bedside nursing gets faded over the period of one year time when they are expected to be at bedside; apparently, most of the concepts are forgotten. Therefore, they require a rigorous exercise to recall the forgotten information, it is not that they do not know it, but it is somewhere in back of their mind because they have learned those concepts probably 1 year or 1.5 years back. So, probably some change is required in the sequence of these courses to produce better nurses.

I asked for Mashal's feedback on the role of senior elective, which, to my knowledge, has been designed to allow the students to integrate knowledge at the bedside. Mashal replied:

> That course [senior elective] is in fact helpful, but again considering that the average experience of nurses working in units is hardly 2 to 2.5 years, so usually

> the nurse who is precepting a student, is probably a team leader or a senior nurse of the unit, who may have the busiest patient besides team leadership responsibility. Therefore, students may not get the required time and guidance, which is needed.
>
> Second, students give their preference for elective in certain areas, but eventually they may be placed in different units rather than where they did their elective. So the comfort that they gain in their elective period is not utilized. I believe that the elective period should be utilized appropriately both for hands-on and for orientation to the unit. What happens now, that we may have four students here for their electives, but later, they are assigned to another unit for work. If I know that these students will come back to our unit, I personally would facilitate them, and I would put a lot of effort to train them rather than leaving them only with bed-side facilitators or preceptors. So, if we have a little modification in the present model, it could probably work out better. It would enhance students learning as well, it would improve the quality of facilitation that is provided at present and it would prepare the graduates in a better way when they come back as a staff nurse. I believe little modification is required if people are listening.

As noted in the previous sections of this chapter, a number of supervisors complained that the graduates have difficulties in coping with their workload as staff nurses. Moreover, most of them showed concern about the graduates' preparation for hands-on skills or psychomotor skills. Hence, in response to the above questions on curriculum improvement, the supervisors offered various suggestions pertinent to the practicum.

Meher proposed that, keeping in mind nurses' expected workload, BScN nurses should be prepared better in terms of hands-on practice in addition to their strong theory base:

> They should have some experience of taking full responsibility for patient care in their program, so that they can have an idea about what they are going to face in professional life. When they come for clinical, usually it is not a complete shift because they stay here from 7 a.m. to 12 noon and not 7 a.m. to 4 p.m., I think, they should be required to work some full shifts.
>
> During their clinical, usually they work with a registered nurse who is entirely responsible for the patient care, so the student know that "if I don't do this, the RN will do that because this is her responsibility." Therefore, the concept of full responsibility is never developed in their mind during their program. Though this is also the same for diploma students. So I suggest that during their student role in clinical, there should be some days where they are required to do patients care without being buddied with a staff nurse, and hence learn to take complete responsibility of the patient care. However, a faculty member should be around to oversee the students because the faculty member, not the head nurse or

> CNT, would know the strengths and weaknesses their students. The student may be assigned to three or four patients with guidance from the faculty member, we may also guide them or oversee them, but the student should be responsible for these patients and no one else.
>
> So I think if we have such system, it will be much easier for them to work later independently. In this way, they will be exposed to real situation and not the ideal situations which they have learned in their student life. Then they won't see things only as black and white, but learn that at time things are grey.

Likewise, Madiha showed concern about the quality of students' supervision during clinicals:

> I am very concerned about the faculty. There are only few senior faculty members to teach students, it is much different than what was in our time. Today's faculty is much different than in the past. In the past, faculty members used to be more concerned about the bedside nursing than sitting in the lounge and only discussing NCPs or whatever, I mean the theoretical aspect of care. I remember, that our teachers used to discuss everything at the patient's bedside, because when you are sitting in the lounge and discuss things, you don't know what your students are actually doing. When you stay at the bedside, you know what is happening. I don't say that all the faculty members are like that, but most of them are. Sometimes their discussions continue from 9-12 AM. So I think this part needs attention. The way we were taught, you would have to do every thing under a teacher's supervision, whether head to toe assessment, medication, or even the patient bed bath, but it is not the same these days. Now, three students may go together to insert an indwelling catheter without a teacher's supervision, and they may be unable to do it, this patient may bleed or get hurt, and finally the unit nurse ends up doing it. In this way, patient suffers and students also loose their confidence if the patient is dissatisfied. So for the next time, students are afraid of taking initiative even if they have the opportunity to perform a procedure. So in term of skills, I think, our AKU-SON graduates are far back than the non-AKU-SON's. I think, their should be more bedside nursing. At present the actual clinical teaching is limited.

Like Madiha and Meher, Mashal, Moona, and Sairah also reckoned that the students' exposure to clinical, especially in the critical care area, was too short and hence needed to change. From Mashal's perspective, although the graduates have had intense exercises in theory, they have not been adequately exposed to or facilitated in caring for critical patients or managing critical situations:

> I feel that the BScN curriculum, particularly the clinical model needs to be modified in a way that they are prepared for critical care nursing as well. Although in their curriculum, they do have some exposure to critical care areas

> and they have their summer and winter clinicals, they are still anxious when it comes to dealing with patients in critical care situations, they don't understand how to do that. So some kind of modification is required in the program, such as the last two months or last three months may be designated for their hands-on with no clinical expectations, assessment or grades, where they are there in the unit for hands-on, because until and unless they practice things, they won't be able to do it.

Considering Mashal's suggestion about the need for more exposure to critical care areas, I asked her, "Do you foresee any problems in employing BScN graduates' on general units after they have done more clinicals in critical care areas during their program?" Mashal responded:

> Yes, I do anticipate that to a certain extent, but I am making this suggestion from a different perspective. In my view, if they are exposed to more critical situations, they will be able to utilize or integrate all the theory they know and exercise their critical thinking and decision making, which they must integrate in their practice by some rigorous exercise. Because of the high acuity of our patients in the hospital, at present almost 32-35 beds are allocated in the special care units within the medical/surgical units, where acuity of these patients is somewhat similar to those in critical care units, such as ICU or CCU. So if these BScN students have more exposure to critical care units, later, patients in general units could also benefit from these graduates. What I am saying is that we should prepare our graduates according to the kind of patient population we have right now in the hospital. A few years back, we did not have very sick patients in our general units, but now we have very critical patients in the special care area in each unit, so the acuity of patients has changed dramatically, therefore, experience in critical care would help them to work in any special care units.

Moona's views substantiated Mashal's suggestions:

> BScN graduates have good theory, but not hands-on skills. I think, there should be more time for practicum in their program. They should be spending more time in the patient care areas and they should be more involved in the patient care. If they can spend more time on practice, then they won't be afraid or hesitant in their skills when they begin to work as a staff nurse. . . . They should have more time for clinicals in critical care areas, such as ICU, CCU, CICU, Recovery Room and Emergency area rather than in the general units because we need more skillful nurses in these areas. . . . If they spend more time in the critical care area, it will be easier for them to work wherever they go, even in the general units, they will not have any problem in adjustment because what they learn in critical care areas, those principles can be applied in non critical care areas too.

Sairah had similar suggestions to those of Moona and Mashal:

> I would suggest to increase their practicum period in a critical care area for the reason that once they are able to handle highly complex situations, it would be easier for them to go and manage simple scenarios in the general units. So their practical experience needs to be increased from what it is now.

Unlike others, Saher proposed some changes in the program to enhance the performance of graduates in specialized areas:

> This is the era of specialization, like you know, you are a urology nurse, or an oncology nurse, or a critical care nurse. We should also begin to work on specialization of nurses. I mean BScN students in their final year may be given a chance to explore their interest areas or pick their preferred areas, provided that there is some liaison between AKU-SON and the Nursing Services at AKUH. The Nursing Services may share their vacancy areas each year and ask students to choose their area of interest and focus on that area in their final year including their assignments and clinicals. So maybe, this will make them more competent and comfortable as staff nurses because you are mentally prepared during your program to work in a specific area. You could have a vision for your career and then you work towards that. So this is one suggestion, but I don't know how practical it is.

### *Summary*

Overall, the supervisors wished to see some improvement in the graduates' hands-on, communication, and interpersonal skills and their professional work ethic, such as their sense of responsibility and accountability, their attitude towards bedside nursing, and their professional commitment. To attain the desired improvement, the supervisors recommended various changes in the curriculum, including to the content and/or the delivery of the content. Some of the above suggestions indicate the need for more collaboration between AKU-SON and Nursing Services at AKUH to improve the outcomes of the BScN program.

## Concluding Remarks

In general, the supervisors yielded a fairly positive perception of the BScN program and the potential of graduates from this program. They were in consensus that BScN graduates were prepared up to their expectations in terms of professional knowledge and cognitive skills, but not in terms of psychomotor skills. Although the supervisors recognized confidence and assertiveness as specific characteristics of BScN nurses, they referred to it with positive and negative connotations. Moreover, they thought that BScN nurses have good teaching/learning and leadership abilities, but the supervisors were necessarily impressed by the graduates' attitude towards bedside nursing. Consequently, they perceived BScN nurses as a distinct group of nurses with specific characteristics. The supervisors seemed to be overwhelmed with issue of high turn over of the BScN nurses at AKUH. Although the supervisors were cognizant of the challenges that were faced by the BScN nurses at AKUH and its possible impact on their retention, they also expressed some doubts about their commitment and devotion to the profession. The supervisors suggested that perhaps BScN graduates have the potential to engage in a variety of nursing roles besides the role of staff nurses, but they were not able to utilize this potential fully for various reasons including poor retention of BScN nurses.

# CHAPTER SEVEN:

# DISCUSSION

This chapter presents the discussion of the findings in relation to the research questions and considers of these findings within the context of extant literature in the field. The discussion of the findings is followed by recommendations to Aga Khan University (AKU), which includes Aga Khan University School of Nursing (AKU-SON) and Aga Khan University Hospital (AKUH), as well as to the nurse leaders of Pakistan. The strengths and limitations of the study are also addressed in this chapter. My final reflections are found at the end of the chapter.

In this research, I explored the experiences of BScN graduates and the perceptions of their supervisors related to the competence of the BScN graduates in the nursing workforce at AKU. This research addressed four questions: How do BScN graduates describe and demonstrate their professional competence? What roles do the BScN graduates play in the nursing workforce at AKU? What factors facilitate or impede the potential competence of graduates in their nursing practice? and What is the perceived contribution of the pre-licensure BScN program at Aga Khan University School of Nursing to its graduates' professional competence? Given the fact that competence is a value-laden and evolving concept, I also asked the participants in this study to identify what constitutes competence in their context and what characteristics they think nurses require to be successful.

For the reader's clarity in this discussion, *informants* and *participants* without adjectives refer to all informants, whether supervisors or BScN graduates, who participated in this study. Similarly, *supervisors* refers to informants in the supervisor category and *graduates* to informants in the graduate category. Likewise, to help the reader to put the subsequent discussion into perspective, it is appropriate first to describe the participants' understanding of the competence and success of a nurse and then to consider their views of BScN graduates' competence.

### Characteristics of Competent and Successful Nurses

The narratives of the informants indicate that they viewed competence as a composite of various elements, including knowledge, skills, values, attitude, and behaviors. They explicitly stated that possessing certain knowledge or skills may not be sufficient to be considered competent unless a nurse is able to integrate that knowledge and those skills effectively into practice to provide safe, holistic, and quality patient care. In other words, similar to the writings of other researchers (Abruzzese, 1996; Campbell & Mackay, 2001; DeBack & Mentkowski, 1986; Gonczi, 1994; Meretoja, Isoaho, et al., 2004; Worth-Butler et al., 1994), the participants in this study had a broader conception of competence that includes an individual's abilities and performance in fulfilling the desired expectations.

In identifying the characteristics of competence, although most of the participants used the term *knowledge* in general, others alluded to specific areas of knowledge such as pathophysiology, pharmacology, and knowledge of nursing processes, theories, and the profession. Most of them talked about problem-solving, decision-making skills, critical-thinking skills. Many alluded to the importance of communication and interpersonal skills. Some of the graduates expanded on the abilities required for effective communication with patients and families, such as patience, emotional control, empathy, and listening skills. It was interesting to note that only one graduate and two supervisors considered *assertiveness* as necessary for effective performance in a specific context, such as advocating for a patient's rights. Both graduates and supervisors equally stressed the importance of having judgment ability and organizational and time-management skills for clinical competence. Similarly, almost every informant highlighted the importance of psychomotor/technical skills. Previous researchers in the North American, European, and Asian contexts have also considered these skills important for competent nursing practice. These includes Alfaro-LeFevre (2002), Bradshaw (1997), del Bueno et al. (1987), Fosbinder (1994), McCabe (2004), Oermann (1997), and Zhang et al. (2001).

In addition to professional knowledge and skills, the informants identified various values, attitudes, and behaviors that they considered important for competence. Consistent with the premise of the nursing profession (Parse, 2003), several participants highlighted the importance of caring or of a caring attitude towards patients and families, and others reflected on other behaviors associated with caring (Alfaro-LeFevre, 2002) such as empathy, sensitivity, respect, and advocacy for patient and family. Despite the fact that cultural sensitivity is an important characteristic of holistic care (Warner, 2002), and is extensively emphasized in nursing education and nursing practices at AKUH, only one supervisor mentioned cultural sensitivity, which might mean that cultural sensitivity is taken for granted, or that it is not seen as being important. However, many participants mentioned family as they spoke of caring for patients, which is important for the pluralistic values of Pakistani culture.

Several supervisors viewed honesty, responsibility and accountability for work, and commitment to the profession as necessary characteristics for effective performance. Some graduates also identified various behavioural attributes related to professional and work ethics, including self-accountability, regularity and punctuality in attendance at work, and teamwork. They alluded to various personal characteristics such as confidence, creativity, vigilance, promptness, and the emotional stability of a nurse to manage patient care efficiently. A few supervisors talked about the need for risk taking in the best interests of patients and tolerance to cope with the stresses of patient care and the work environment. Similarly, one supervisor emphasized the ability to provide patient care within the given resources, which requires not only creativity, but also flexibility in nurses' attitudes towards managing patient care. Although professional organizations commonly expect most of the above-stated abilities and behaviours from nurses, as noted earlier in Chapter Two of this dissertation, the expectation that they should be able to work with limited resources is not so explicit in the literature. Nonetheless, it is relevant to the context of developing countries, where the scarcity of resources is a common challenge for nurses. Overall, what constitutes competence within the context of AKUH is consistent with the work of other authors in international literature, such as the work of Godin (1996), Liu (2004), Ramritu and Barnard (2001), and Zhang and colleagues (2001).

The participants identified similar attributes to describe a successful nurse as they did for effectiveness in clinical practice, albeit with more emphasis on a nurse's professional development abilities. Moreover, both graduates and supervisors noted that successful nurses can ensure patient as well as self-satisfaction by providing safe and holistic care. It is important to mention that in their narratives, although the graduates used both *safe* and *holistic*, the supervisors did not use holistic. It was also interesting to note that in discussing professional development activities, the graduates talked about *self*-development, whereas the supervisors talked about developing self as well as other colleagues in the profession by mentoring or role modeling. Although both graduates and supervisors regarded clinical competence as one of the important indicators of success in nursing, the graduates indicated that a nurse's ability to play multiple roles is also necessary to be regarded as successful. Such differences between graduates and supervisors in their descriptions of the success of a nurse may be attributed to the differences in their professional preparation, their current position, their individual values, or the generational diversity that has the potential to shape their views of nursing differently (Sherman, 2006).

## Graduates' and Supervisors' Experiences and Perceptions of Graduates' Competence

The participants in this study perceived BScN graduates as a distinct group of nurses with specific capabilities and characteristics. They reflected on various elements of competence that they thought BScN graduates possess or demonstrate, including knowledge, skills, attitude, and behaviors. Most graduates reported being proud to be a BScN nurse, and they frequently acknowledged their broad theoretical knowledge, critical thinking ability, professionalism, and confidence in their communication skills. They valued and wanted to provide holistic care and strove for continuous learning. From their narratives on the benefits of their nursing program, it is evident that BScN nurses at AKUH have discerned the distinct values of the degree program in nursing and are determined to apply them in their practice.

As noted elsewhere, the supervisors compared the performance of BScN graduates with that of diploma graduates and reported that the BScN graduates have sound knowledge and tend to surpass diploma graduates in critical-thinking, problem-solving, and decision-making abilities; self-directedness; leadership; and teaching/learning activities. The graduates' self-perceptions of these elements of competence corroborated the supervisors' views. In general, these abilities are expected of degree nurses, and similar to the findings of this research, the outcome of baccalaureate education is acknowledged increasingly in the literature (Bartlett et al., 2000; Beeken, 1997; Cruickshank et al, 1994; Dennis & Janken, 1979; Goode et al., 2001; Johnson, 1988; Ryan & Hodson, 1992; Waters et al., 1972).

The informants provided many examples of patient care practices that would be labeled as safe clinical judgment by Goode and Williams (2004), such as timely recognition of deviations in patients' status and of the need to call physicians with essential data or question the decisions of medical staff if they appeared inappropriate. In general, the findings reveal that, with some exceptions, the graduates possessed good clinical competence. Clinical competence consists of technical skills, organizational ability, and clinical judgment, which comprises clinical knowledge and clinical decision making (Benner, Tanner, & Chesla, 1996a). Although the supervisors affirmed that BScN graduates have sound theoretical knowledge and critical-thinking ability, in their view, initially, graduates find it difficult to integrate theory into practice. However, once the graduates pass through their initial three- to six-month period of adjustment on a nursing unit, their clinical judgment improves, and they make sound decisions to enrich patient care. This finding affirms that clinical judgment is developed through integrating experience and formal knowledge (Ferguson, 2006). Oermann and Moffitt-Wolf (1997) explained that clinical judgment is grounded in critical-thinking skills, but the development of clinical judgment is associated with experiential knowledge; therefore, although the foundation for clinical judgment may be inculcated in nurses in their professional education, it cannot be fully developed without sufficient clinical experience.

Both graduates and supervisors reported that novice BScN nurses lack time-management and organization skills and do not use their psychomotor skills efficiently. These temporary shortcomings of new graduates are well documented in the literature (Duchscher, 2001; Ferguson & Day, 2007; Khoza & Ehlers, 1998; Lowry, Timms, & Underwood, 2000; Oermann & Moffitt-Wolf, 1997). For example, in South Carolina, Lowry et al. surveyed 68 nurse managers and educators to identify the expected competencies of graduates from Clemson University. They reported that Clemson's new graduates were valued by their supervisors, for their professional behavior, patient assessments, broad knowledge, and desire and eagerness to learn. However, they were perceived least prepared in terms of organizational and time-management skills, their ability to manage groups of patients and perform basic clinical skills and procedures, and their lack of teamwork and leadership skills. The supervisors in the current study revealed strikingly similar views; however, unlike Clemson's new graduates, the supervisors recognized AKU-SON graduates for their leadership as well as teaching/learning abilities, but many of them were not impressed with the graduates' professionalism.

Consistent with the findings in Johnson's (1988) meta-analysis of the characteristics of nurses from different educational programs, the informants in the current study affirmed that BScN nurses have strong communication skills. Despite the prevailing hierarchies in their work environment, the graduate nurses' boldness in their interactions with medical staff in advocating for patients' needs and in their interactions with nursing management staff was evident in this study. Recently, Lalani (2005) examined the adaptation process of new diploma graduates with six to eight months' experience at AKUH and reported that the diploma graduates lacked confidence in communication with medical staff. In contrast, the supervisors in the current study viewed confidence and assertiveness as specific characteristics of BScN nurses. A positive self-concept can increase nurses' sense of self-worth and self-confidence, which in turns enhances their ability to utilize learning experiences in an optimal manner and results in high performance (Cowin & Hengstberger-Sims, 2006). Consequently, these findings lend credence to the effectiveness of the BScN program at AKU-SON.

Despite the graduates' positive self-perceptions of their confidence and assertiveness, the supervisors presented varied views of these characteristics in BScN graduates. Although the supervisors appreciated the graduates' confidence in their communication with medical staff for patient advocacy, they also noted some drawbacks in their communication skills. They pointed out that at times BScN nurses go too far and become aggressive because they are unable to recognize the difference between assertiveness and aggressiveness, which consequently affects their work relationships with nursing colleagues. However, none of the supervisors reported BScN nurses' aggressiveness or rudeness to their patients or the patients' families. This is an interesting finding, and I wonder why BScNs are perceived to have problems only with nursing colleagues. Literature on generation differences (Duchscher & Cowin, 2004; Sherman,

2006) indicate that people of the younger generations of North American people value work-life balance and are less likely to sacrifice their own plans to accommodate the needs of their work unit, such as a request for overtime work, and hence may be "perceived as being abrupt and sometimes abrasive in their communication style" (Duchscher & Cowin, p. 499). Perhaps a similar phenomenon is also at play in Pakistan.

Several supervisors expressed disappointment with the perceived carefree attitude toward accountability and supervision of BScN graduates. The supervisors used contrasting adjectives to compare diploma and BScN graduates; they referred to diploma graduates as respectful, courteous, and polite; whereas they referred to BScN graduates as impatient, arrogant, rude, hyperactive, and short tempered. Some supervisors questioned the commitment of BScN graduates to the nursing profession when they openly turn down their supervisors' request, for example, to work a double shift. Several supervisors felt challenged in interacting with BScN graduates because they considered BScN graduates idealistic, demanding, and change oriented rather than accepting the status quo. Moreover, they considered BScN graduates vocal and expressive and felt that they have a sense of superiority over others. The supervisors attributed these behaviours and attitudes of BScN graduates mainly to their family and schooling background and their professional preparation in the BScN program at AKU-SON. However, a growing body of international literature has described similar behaviours and attitudes among the two younger generations of this era (Calhoun, 2005; Duchscher & Cowin, 2004; Sherman, 2006; Wieck, Prydun, & Walsh, 2002).

Duchscher and Cowin (2004) posited that at least four generations work in the nursing force in North America and categorized them by their years of birth: veterans (1925-1945), baby boomers (1946-1964), generation X (1965-1980), and the millennials or generation Y (1980-2000). They recognized that although these demarcations are not absolute, each generation spans a period of 15 to 20 years. Influenced by historical, political, and socioeconomic events, each generation has different values, which in turn affects their attitude to work ethics and authority and to their professional aspirations. For example, in contrast to the two older generations, generation Xers are described as being alienated, individualist, nonconformist, and unimpressed with authority and rigidity, but preferring flexibility and being less willing to sacrifice their personal plans for the sake of work. Although millennials share some characteristics with generation Xers, they are typically recognized for their affinity to change over stability and their desire for countless options, customization, and feedback (Calhoun, 2005; Duchscher & Cowin). As noted above, BScN graduates in this study have most of these characteristics.

Considering the age difference between BScNs and their supervisors, it is plausible that BScNs would subscribe to different values from those of their supervisors. However, why are BScN graduates different from diploma graduates despite the fact that they were born within the same generation? Although this question warrants some research, a possible explanation could be that, in general, BScN nurses come from a comparatively affluent class with more access to Western media or technological advances; hence, they are more influenced by the modern values of the world.

### Roles of BScN Graduates in the Nursing Workforce at AKU

As described earlier in Chapter Four, the majority of the BScN graduates initially worked as staff nurses at AKUH to gain clinical experience and then moved on to other roles, mainly teaching, but also management in some cases. However, a few graduates joined Aga Khan Community Health Sciences to work on research projects that required a combination of patient care, teaching, and research skills. This seems to be the beginning of a new trend in Pakistan in which nurses may not necessarily have to join a hospital to begin their careers in nursing. At the time of my data collection, the majority of the BScNs graduates were working at AKUH and some at AKU-SON. However, it is relevant to mention that several BScN graduates, particularly the males, were working in teaching positions at schools of nursing other than AKU-SON.

The differences in the employment patterns of males and females graduates can be attributed to many factors. For example, the majority of male graduates were not local but from the Northern Province of the country; hence, they joined an institution that is closer to their hometowns. In addition, there was less competition for male graduates to obtain leadership positions at a non-AKU organization, and their salaries were higher than those at AKUH. Similarly, in general, women in Pakistani society are less mobile than men and prefer to work in a more familiar place rather than moving to a new place. However, the male graduates indicated that, in general, the nursing culture at AKU is not as welcoming for male graduates as it is for female graduates. To support their perception, they alluded to the fact that there was no male teacher at AKU-SON and only one male nurse in an administrative position at AKUH. Therefore, the male BScN graduates looked for opportunities at organizations other than AKU while they were in the final years of their program. If nurse leaders at AKU support a rich nursing workforce and wish to capitalize on the strengths of male nurses (Kleinman, 2004; O'Lynn & Tranbarger, 2007), then they must make an effort to recruit and retain male nurses.

As noted elsewhere, BScN nurses constitute 10% of the nursing workforce at AKUH, of which nearly half work on critical care units; however, several of those on the general units are usually assigned to care for patients with complex needs in the special care areas of the general units. Although many of the participants were working as staff nurses because they had less than one year of experience, among those with three to four years of experience, seven were working in a teaching role as CNIs or nursing education instructors, whereas only one was working as a head nurse and one as a case coordinator. Of the five CNIs, three were on critical care units, which can be explained by the fact that a good number of BScNs initially join a critical care unit and then later qualify for a vertical promotion. The informants' accounts reveal that many were actively participating in teaching/learning activities whether they had a formal teaching position or not. Similarly, many of them were given the opportunity to work as team leaders; several supervisors acknowledged their preference for BScN over diploma-prepared nurses as team leaders.

The graduates perceived their roles as challenging, important, and responsible regardless of whether they worked as staff nurses, team leaders, or teachers. They expressed a sense of pride and satisfaction in being involved in teaching/learning activities besides working as bedside nurses. Various factors may contribute to this phenomenon: the graduates' competence in this area, their value for lifelong learning, role expectations, and/or the availability of opportunities to teach. This is a potentially important finding because nurse managers may capitalize on this finding and use it as a motivational strategy to enhance nurses' work satisfaction.

Several supervisors perceived that most of the BScN nurses are not keen to work as bedside nurses but, rather, consider their degree as a gateway to leadership—teaching or administrative positions. From the supervisors' perspectives, it is as a major issue because it affects the much-needed contribution and retention of BScNs in direct patient care. The views of employers and the post in which the graduates function are known to have some influence on competence development and utilization (Kapborg & Fischbein, 2002; Manuel & Sorensen, 1995). Information from the graduates, particularly the initial three cohorts, substantiated the supervisors' perceptions about BScNs aspirations towards leadership positions.

The graduates identified various reasons for their inclination to desire leadership positions. Because at the completion of their program, post-RN BScNs are offered first-line administrative or teaching positions at AKUH or AKU-SON, BScN graduates assume that they will be performing in the same capacity or positions because of their degree education, but without realizing that they first need to acquire experience as bedside nurses before they can be promoted to a higher position. Moreover, differences in the admission criteria for the diploma and BScN programs and in their courses also leads BScNs to believe that they will be working in a supervisory position because they are better prepared than diploma nurses are. Some graduates also indicated that their capability was questioned by their classmates, family, and friends when they continued to work as a bedside nurse despite being a degree holder. Based on my analysis of data, the disparities of salaries and benefits between bedside nurses and those in leadership position is an important contributory factor in this issue.

Talking to nurses from developing countries, my understanding is that at times nurses may earn more money as bedside nurses than those in teaching or administrative positions. Likewise, a differential shift allowance is offered to nurses for working in evening and night shifts and on weekends. For example the University of Missouri Health Care (2006) offers an additional per hour pay of $ 2.75 and $ 4.00 for working evening and night shifts respectively. Such practices could be useful to attract nurses to work less desirable hours, but they did not exist in AKUH at time of data collection for this study. In general, bedside nurses in Pakistan have a lower salary than those in leadership positions, and AKUH follows this principle. Moreover, as I described in the second section of Chapter Six, BScN graduates at AKUH earned a lower salary than their counterparts in AKU-SON and other nursing organizations in the country. This issue is further complicated by the fact that many private health care organizations in Pakistan have been successful in attracting AKU-SON prepared nurses for teaching or administrative positions on a comparatively higher salary than they can earn as a bedside nurse at AKUH. Besides earning a higher salary, it is considered more prestigious to work in a leadership position and one does not work evening or night as is required of the bedside nurses.

Findings indicate that the issue of expected positions was most intense in the first cohort of BScN nurses and has led to serious interpersonal conflicts between BScN nurses and management staff that still continue, although with less intensity. BScN graduates are increasingly realizing the value of experiential knowledge; however, at times they perceive resentment from the management staff and senior colleagues, especially the nondegree nurses. Socialization of BScN and diploma nurses is a major finding of this study. Graduates in Canada also continue to experience negative attitudes from seasoned hospital trained nurses (Duchscher, 2001; Ferguson & Day, 2007), but not to the extent as found in the current study. This could be explained by the fact that introduction of BScN graduates in nursing workforce is fairly new in AKU, Pakistan compared with North American countries, where such professional interpersonal conflict have been diffused now. With appropriate strategies and planning, lesson learned through stories of participants in this study could be utilized effectively in other institutions of Pakistan where the new BScN graduates are expected to join the work force in the near future.

The findings also reveal that BScN graduates are receiving mixed messages from their supervisors. For example, on one hand, the supervisors preferred BScN nurses over diploma nurses for team-leader positions, and therefore many of the BScNs were assigned to team-leader positions within the first six months of their work as staff nurses; yet, on the other hand, the supervisors followed similar promotional policies for diploma and BScN nurses. This is an important issue that the nursing management must address. In addition, these findings have a wider applicability to other nursing institutions that have recently implemented a BScN program or are planning to implement one. Nurse leaders in these institutions must implement strategies to prevent such undesirable consequences to occur.

A few supervisors also asserted that BScN nurses refrain from or avoid engaging in patient hygiene care because their interests lie in leadership activities. Although some graduates affirmed this perception, other graduates and supervisors rejected this assertion. Conversations with the informants revealed that it is a general issue in nursing and not specific to BScN graduates, and male nurses might consider it more embarrassing (Inoue, Chapman, & Wynaden, 2006) than female nurses do to engage in hygiene care of patients. If I analyze this within the context of Pakistani society's perceptions of gender roles, the tasks of washing and cleaning are perhaps more acceptable for women than for men. However, such tasks are not considered prestigious for both genders because many people, especially noneducated women from the lower social class, earn money by working as home servants for people from the upper and middle classes.

As a male graduate in this study reported, the patient felt pity for him and thought that he was not as educated because he had been assigned to hygiene care. Another female graduate shared that her father is proud of all of the roles that she performs as a nurse except for those that involve basic care. In other words, society does not value this aspect of nursing; in fact, it is a contributing factor to the low image of nurses in Pakistan (Gul, 1998). Moreover, as a supervisor explained, nurses question the value of their extensive educational preparation when they are predominantly involved in basic care activities and do not have time to offer holistic care. Hence, nurses in the general units might avoid tasks that are a hindrance to their ideal of holistic care (Henderson, 2002) and which affect their professional image negatively.

## Contextual Factors Affecting the Potential Competence of Graduates

All graduates shared vivid memories of their transition from a new graduate to a confident professional. Their accounts affirm the significance of this period for its long-lasting effect on their attitude towards clinical nursing and their decision to continue or leave the organization and/or profession, which is consistent with the findings of other researchers (Cassells et al., 1986; Cowin & Hengstberger-Sims, 2006; McKenna et al., 2003; Roberts et al., 2004; Speedling et al., 1981). Many factors seemed to influence their transition from student to staff role, including personal characteristics, professional capabilities, interest in and familiarity with their work environment, orientation, work unit, professional socialization, nurse-physician relationship, role autonomy, and workload, which in turn influenced their ability to practice competently.

### *Orientation*

The graduates reported wide variations in their experiences of orientation. Detailed competency-based orientation (CBO) checklists were available on the units; however, utilization of CBO was inconsistent across units. The graduates found it helpful when the CBO was conducted at the right time with appropriate mentorship from the clinical nurse instructor (CNI) or senior colleagues, including nurses and critical care technicians (CCTs). Consistent with the findings of other researchers (Beecroft, Kunzman, & Krozek, 2001; Brasler, 1993; Ferguson, 2006; Marcum & West, 2004), the graduates appreciated initially being buddied with experienced nurses for a few shifts. They were also thankful that they initially worked mornings for two to four weeks before they began to work on rotating shifts. Moreover, those who had a chance to work with the same group of nursing staff consistently in the initial few months found it very useful. However, it was stressful to the graduates when none of these steps were followed on their work units and they were required to make multiple adjustments simultaneously, including to the new role, environment, people, and work hours. As Halfer and Graf (2006) noted, the new graduate nurse's career adjustment is not limited only to mastery of clinical skills, but also includes lifestyle adjustment. Hence, nurse clinicians must be cognizant of these stressors and their consequences in dealing with the orientation of new graduates on their units.

The graduates also found it very useful to be assigned to the same unit where they had completed their senior elective because familiarity with the work environment, including unit routines and resources, and staff, lessens the anxiety of the unknown and hence helps them to adjust quickly. However, in such cases the unit management had higher expectations of the graduates and in some cases either cut short or completely omitted their orientation process, which is consistent with practices elsewhere (Bryant & Williams, 2002; Ferguson, 2006). Similarly to the participants in Ferguson's study, although the graduates did not appreciate such practices, they thought that the advantages of being assigned to the same unit outweighed the disadvantages. I believe that the unit management's involvement of new graduates in cutting back on some parts of the orientation could eliminate some of these concerns, and new nurses and their management staff might have a better professional relationship.

### *Work Area and Choice of Unit*

Graduates who were assigned to their area of interest demonstrated more stamina in coping with the challenges of the transition period because their internal motivation empowered them to learn to enhance their competence in that area. Existing research on new graduates has indicated that their level of stress depended on, among other factors, whether or not new graduates worked on their first choice of nursing unit (Beecroft, Santner, Lacy, Kunzman, & Dorey, 2006). In this study, some graduates did not accept the offer or left their work within the first few months if they were not assigned to their area of interest. Although it is not so explicit in the existing literature on this topic, the findings of this study suggest that graduates' assignment to their choice of unit might strongly influence their commitment to and retention in the organization.

As noted earlier, nearly half of all new graduates were assigned to the critical care area, where they are required to care for high-acuity patients with complex needs. Although these graduates were initially anxious because of their lack of confidence in their skill performance, they reported fewer issues with regard to their transition from the student to staff role. They had been given an extensive unit orientation before they were assigned to work independently, the CNI closely mentored them and facilitated their work, and they had more collegial support in their work environment than their counterparts on the general units had; hence they adapted faster to their new environment.

Considering the neophyte nurses' level of confidence and competence and their development needs intellectually and emotionally, some researchers (Duchscher, 2001; Ramritu & Barnard, 2001) cautioned about clinical safety issues when new graduates are assigned directly to highly acute, fast-paced clinical areas that require unusually high levels of clinical judgment and problem-solving skills. However, because of the increasing shortage of nurses, also obvious in this study, new graduates are being assigned to high-acuity patients with complex needs (Casey et al., 2004; Goode & Williams, 2004). Evidence in the current study suggests that graduates are able to cope with complex patient care provided that their work environment is supportive. This finding is consistent with those of Oermann and Moffitt-Wolf (1997), who reported significant correlations between social support and stimulation in clinical practice and the development of self-confidence among new graduates, which in turn is known to influence graduates' adaptation to and performance in the new environment (Cowin & Hengstberger-Sims, 2006; Hurst & Koplin-Baucum, 2003).

In addition to learning and a supportive work environment, the one-to-one nurse-to-patient ratio might be another reason for graduates' better adaptation to critical care because caring for one patient requires relatively fewer organization skills than caring for 8 to 12 patients does. Moreover, the ability to provide holistic care, also as noted in this study, closely relates to the ideals of BScN graduates (Henderson, 2002) and hence may add to their sense of achievement and satisfaction. Finally, those graduates who worked in critical care units had a better perception of their role because they were more involved in patient-care decisions and their input into patient-care decisions was often valued. Kangas et al. (1999) studied the effect of the relationship of various organizational factors, including the type of work unit, on nurses' and patients' satisfaction. They reported that working on a critical care unit and perceiving the work environment as supportive are strongly related to nurses' job satisfaction and patients' satisfaction. In sum, multiple factors contribute to graduates' satisfaction on critical care units.

Those graduates who worked in a teaching role other than AKUH appeared more satisfied than their counterparts at AKUH. Although no definite conclusion can be reached without further exploration, this finding could be a result of the differences in role autonomy, work environment and work conditions, salary, or professional self-image. The environment in which nurses practice contributes to their professional self-image (Siebens et al., 2006).

### *Learning Environment*

In general, the graduates expressed a sense of satisfaction if they had opportunities to participate in teaching/learning activities because such opportunities allowed them not only to enhance, but also to demonstrate their competence. It boosted their morale when their colleagues took an interest and facilitated the availability of learning opportunities. Although it was not always welcomed, the graduates were also very willing to share their knowledge with colleagues; some of them shared their stories with great pride about taking an inservice session, coaching, precepting, or mentoring another person on the unit. Similar to the participants in Ferguson's (2006) study, graduates also appreciated inservice presentations, special courses or seminars pertinent to their client populations, and an environment that gave them an opportunity for informal exchange of professional information; this finding corroborates with the values of the younger generations (Duchscher & Cowin, 2004; Sherman, 2006).

### ***Professional Socialization***

The current literature revealed that collegial support and feedback from experienced nurses are crucial to the development of and actualization of competence among novice nurses (Benner et al., 1996b; Beecroft et al., 2006; Ferguson & Day, 2007; Oermann & Moffitt-Wolf, 1997; Ramritu & Barnard, 2001). Unfortunately, AKUH has a limited number of experienced nurses to support neophyte nurses because nearly 67% of nurses are novice and quite young, which in itself is a ground for conflict and burnout. Moreover, the tension between diploma and BScN nurses, as noted elsewhere, also has a negative influence on the socialization of new graduates. Consequently, only a few graduates could receive partial support from their colleagues and/or management.

Both management and colleagues had high expectations of the graduates. Although not realistic, they were expected *to know everything* as they were going through the developmental phase of their career; otherwise, their identity as BScN nurses was often challenged. Their narratives indicate that their senior colleagues criticized, discouraged, taunted, intimidated, resisted, and resented them, which they described as shocking, hurtful, crushing, pressurizing, and demotivating and which consequently hindered their learning needs and suppressed their existing abilities. Such interactions in the literature are called *bullying*, *horizontal violence*, or *psychological harassment*. They are considered detrimental to the self-esteem and self-confidence of new nurses (Cowin & Hengstberger-Sims, 2006; Lee & Saeed, 2001; McKenna et al., 2003) and viewed as a barrier to optimum clinical competence (Duchscher, 2001). The graduates used different strategies to overcome this challenge such as ignoring it, working harder to prove their worth, fighting back, or giving up and leaving the institution, which substantiates Hurst and Koplin-Baucum's (2003) findings.

### *Nurse-Physician Collaboration: Role Autonomy*

The findings do not suggest a cordial, supportive, or collegial nurse-physician relationship at AKUH, but rather a hierarchical working relationship. Although some members of the medical profession respect nurses' input into patient-care decisions, they occurred in individualized instances and were not the norm. The BScN graduates were not reluctant to voice their opinions or suggest appropriate action relevant to patient care, but the receptivity of their input was not always encouraging; in fact, marginalization of their role (Lee & Saeed, 2001) was evident. For example, a surgeon ignored her suggestion when a novice graduate recommended informing the family members in advance that a tracheostomy had been planned for the patient for the next day in order to prepare them mentally for the procedure. The recurrence of such experiences could easily damage nurses' self-confidence and self-concept and affect their clinical competence. The nature of nurse-physician collaboration is associated with nurses' ability to deliver patient care and with their work satisfaction (Vahey et al., 2004) and consequently influences patient-care outcomes (Baggs et al., 1999; Kangas, Kee, & McKee-Waddle, 1999; Sabiston & Laschinger, 1995).

The graduates also reported that nurses are usually met with resistance and sarcasm if they try to reinforce infection-control practices involving medical staff. They pointed out that, on one hand, nursing management expects nurses to follow and ensure proper practice and be patients' advocates; but, on the other hand, nurses do not have much support in the system. In other words, nurses have responsibility without sufficient authority (Finn, 2001) although authority is an important element of autonomy. In my view, AKU as an organization must explore and attend to this issue to improve the nurse-physician relationship at AKUH.

### *Workload and Overtime*

A major issue in this study that the participants identified is the staff shortage and its associated effects, including high workload and the need for double shifts. Taris (2006) found that exhausted workers perform less efficiently than others because they do not have sufficient energy to deal with the demands of their jobs. Excessive workload affects nursing caring behaviors; causes exhaustion and burnout (Ervin, 2006); leads to unfinished tasks such as hygiene care, documentation, or patient teaching and counseling;

and endangers patient safety (Sochalski, 2004). The graduates' stories also reveal these effects. Usually, nurses at AKUH remain on the unit after their shifts are over because they are required to complete unfinished tasks either voluntarily or because their colleagues or management have demanded that they do so. As a result, many times they miss their regular transport, which adds to their cost and is stressful. Moreover, nurses question the support of their management when they are expected to perform up to international standards with limited staffing.

In a study of 393 hospital staff nurses, Rogers et al. (2004) found that the risk of making an error significantly increases when nurses work longer than 12-hour shifts or more than 40 hours per week. Staff nurses at AKUH are already required to work 45 hours a week and are requested at least once a week to work a double shift, which means 16-17 hours at a time. Considering these facts, it is not difficult to understand the high turnover of nurses at AKUH, especially when there is no dearth of job opportunities for nurses outside AKUH.

## Perceived Contribution of the BScN Program to Graduates' Professional Competence

Some supervisors more explicitly than others stated that, in general, they expect better performance from BScN graduates than from diploma graduates. They expect BScNs to perform better in direct patient care as well as in terms of teaching and leadership activities. All graduates were very aware of these expectations because not only did their supervisors and nursing colleagues communicate these expectations to them verbally or nonverbally, but the graduates also had high self-expectations to prove their worth as degree nurses. In general, the informants were cognizant of variations in graduates' performance in spite of the fact that they graduated from the same program.

The graduates believed that they were prepared effectively to enter nursing, with strong foundational knowledge and transferable skills—critical thinking or self directed learning that can be used in multiple settings such as hospitals, community, or schools. The graduates valued the critical-thinking skills that they had acquired from their program and considered them essential to rationale-based scientific practice. They also highly appreciated their teaching/learning abilities, which they felt helped them not only in their role as a nurse in the hospital or school of nursing, but also in their voluntary services in the community and for their continuous professional development. Some informants pointed out that the combination of a broad knowledge with cognitive skills—critical thinking and problem solving as well as communication skills help the BScN graduates to excel in their leadership abilities.

The graduates reported that they are able to apply in their practice most of what was included in and was taught in their program, but the usefulness of specific courses or skills varied depending in their area of work. For example, two graduates wondered about some areas of preparation in their formal education, such as nursing care plans, concept mapping, in-depth health assessment skills, or extensive paper writing skills, which they were unable to apply because the lack of time related to workload or it was not expected of them as staff nurses. Likewise, several graduates reported positively on their ability to advocate for patients and gave examples of its usefulness in practice, but two graduates felt that they were not completely autonomous in voicing their concerns and depended on the support of senior nurses. This finding is congruent with the evidence from other studies (Duchscher, 2001; Ferguson & Day, 2007). Considering these findings, I think educators need to enhance the graduates' awareness about some of the challenges in the work environment and the possibility that one may not be able to apply all the learned skills in their first position, but most probably at another point.

A few informants also pointed out that BScN nurses initially find it challenging to deal with patients' families. The new graduates in Duchscher's (2001) research also reported this difficulty. They described feeling distracted and disturbed when they had to answer questions from patient families when they were striving to complete routine patient-care tasks. However, informants in the current study associated the said difficulty with the graduates' lack of exposure and experience in dealing with sensitive situations in their program. Similarly, one supervisor expected BScN graduates to be better prepared to handle their own and patients' emotions, but at the school level rather than nursing services because there is "nobody to mentor them" there. From her perspective, graduates who have these skills can help themselves as well as their colleagues and can be more effective in dealing with patients' emotions. My reflection on this suggestion makes me wonder how much should we really expect from an entry level program and from the new graduates if they can not be properly assisted with their own developmental needs?

Unlike with their teaching/learning abilities, only a few graduates were able to make use of their knowledge and skills related to research. Although most graduates expressed their desire to be involved in research, they were not facilitated by the contextual factors for research utilization (Meijers et al., 2006), such as access to resources, organizational climate and support, but mainly time for research activities. Although supervisors also acknowledged these factors, they pointed out that BScNs lack initiative in this area of performance. However, it is worth mentioning that although the performance appraisal form for staff nurses in the North and South units listed "self development and participation in educational activities" as an expectation, non of the research utilization criterion was mentioned. According to Titler and colleagues (1994) research utilization includes using research findings in practice, encompassing the dissemination of scientific knowledge, critique of studies, synthesis of findings, determination of applicability of findings, application or implementation of findings into practice and evaluation of the practice.

Analyzing their narratives, I noted that some informants lacked clarity about the graduates' ability for research related activities. For example, some supervisors thought that BScNs could take lead for conducting small research projects, but they are only prepared for research utilization. However, to use their potential effectively with regards to research utilization, the supervisors should include this as part of the BScNs' performance expectation and provide them with appropriate support to actualize this expectation.

The graduates from the older cohorts appreciated their formal education more than did the graduates of most of the recent cohorts. This finding is consistent with the findings of other researchers (Ferguson, 2006; Kapborg & Fischbein, 2002). Although these authors did not elaborate on the reasons for this change in graduates' satisfaction over time, two factors can be attributed to such change in view of the data in the current study. The majority of new graduates began their nursing career in hospital settings as staff nurses, which, also noted in this study, demands better organizational skills and more efficiency in skills performance to manage their patient workload than the other theoretical skills that graduates learn in school (Smith, 2002). Hence, most graduates initially have a sense of inadequacy because they are unable to apply what they know the most, but they are required to apply what they feel least prepared for. Then, once their initial period of adjustment is over and they have mastered practical skills and had the opportunity to demonstrate their teaching/learning and leadership skills, their professional self-concept improves (Cowin & Hengstberger-Sims, 2006), and they are in a better position to recognize the value of their formal education.

Although most graduates in this study expressed their satisfaction with their educational preparation in the BScN program, they all explicitly acknowledged the value of experiential knowledge and continuing education. One graduate reported that in her program she had learned how to catheterize a patient, but she did not know how to catheterize a restless patient while maintaining the principles of asepsis. Another graduate explained that she knew the principles of communication and interpersonal skills, but she did not know how to deal with the family members of a patient with a terminal condition. In other words, the graduates needed some experiential knowledge to contextualize their formal knowledge according to their client population as well as the norms of a specific nursing unit which, as the findings in this study also show, created a sense of inadequacy among the new graduates (Bjork, 1999a), and which they overcame within the first three to six months of practice depending on individuals' variations and their area of work, similar to what other researchers have noted (Benner et al., 1996b; Duchscher, 2001; Ferguson, 2006). However, some informants in this study considered the process of developing competence in practice as a shortcoming of the program and called it the *theory-practice gap*.

Supervisors reported that at times BScN graduates are unable to modify the idealistic approach to patient care that they have learned at school and are then faced with disappointment and disillusionment because its does not work in practice. Hence, they advised that the BScN curriculum should be more integrative of the nursing practice realities in order to prepare graduates with pragmatic knowledge instead of only theoretical knowledge. This concern about theory-practice has been consistently pointed out in nursing literature (Adamczyk, 2006; Greenwood, 2000; Henderson, 2002; Kramer, 1974). However, in my view, this concern is arguable and could be detrimental to the needed improvements to nurses' work environment. For example, in reference to the idealistic approach taught in the school, one graduate said, "if we don't know the ideal ways of practice, we will not be able to differentiate between what is acceptable and what is not acceptable."

Graduates in this study as graduates studied by Ferguson (2006) considered their clinical experience as a student, the most useful component of their program because of its immediate applicability to nursing practice; however, a number of graduates thought that they had limited opportunities for hands-on practice in their clinicals during the program and hence, upon entry to practice as staff nurses, they found themselves inadequately prepared for technical and psychomotor skills, such as I.V. cannulation and participation in providing advanced level cardiopulmonary resuscitation. Whereas some graduates reported that although most of the knowledge and skills required for patient care were acquired in the program, some of their abilities were developed or enhanced once they began to work as a staff nurse. Similar findings are noted in the literature (Casey et al., 2004; Cassells et al., 1986; Ramritu & Barnard, 2001; Speedling et al., 1981). Like the graduates, supervisors also thought that BScNs could be better prepared for their hands-on skills.

The supervisors raised many concern about the graduates ability with regards to performance of technical and psychomotor skills and considered them at a similar level as the diploma graduates. Some of them indicated that within the current system of clinicals in the program, the students are unable to develop a sense of ownership and accountability for patient care because usually they are buddied with a staff nurse instead of having an independent patient. They also pointed out that during clinicals students are there for about 5 to 6 hours a day and not a complete shift of 8.5 hours, and they are usually assigned to a single patient; consequently they are unable to mange a full load of patients' assignment upon entry to practice. Some supervisors also reported that quality of student supervision is not as good as it was in the past. Hence, the supervisors offered various suggestions for enhancement of the clinical component of the BScN program as described in the last section of Chapter Six.

As I noted earlier in Chapter One, nursing students at AKU-SON have two types of clinicals: the Fall and Spring clinicals that are supervised by faculty members and the Summer and Winter clinicals in which students are buddied with and supervised by the staff nurses at AKUH. In the former type, students may not work a full shift as indicated above by the supervisors in this study; however, students not only do complete shift hours but work rotating shifts during their summer and winter clinicals. The current BScN program at AKU-SON requires a total of 3951 hours of clinical, including 1440 of summer and winter clinical, which are 954 more hours than the diploma program at AKU-SON. Moreover, the requirement of clinical hours in the BScN program at AKU-SON is much higher in comparison to Canadian Universities. For example the BScN program at the University of Alberta consists of 1596 clinical hours, which is 2355 less than those required at AKU-SON.

Considering the above facts, I wonder why BScN graduates are still not able to perform up to the expectations of the nursing services? There must be other reasons than the required numbers of clinicals hours, which requires further exploration at AKU. However, the discontent of nurse clinicians over graduates' psychomotor and technical skills has been well noted in the literature (Adamczyk, 2006; Cassells et al., 1986; Elkan & Robinson, 1993; Moeti, van Niekerk, & van Velden, 2004) because despite the increasing focus on a holistic approach to conceptualizing nurses' professional competence, the reality of nursing practice continues to demand task accomplishment (Bradshaw, 1997; Greenwood, 2000; Watson, 2002). A recent evaluation of Australian undergraduate pre-registration nursing curricula from 29 universities found that overall the graduates are well prepared for practice; however, quality and coordination of clinical learning were highlighted for improvement (Leibbrandt, Brown, & White, 2005). Some researchers suggest that a lack of definition of the essential skills for BScN graduates at the entry level could be one reason for this discontent (Lindeman, 1996; Ramritu & Barnard, 2001; Sweeney et al., 1980), which appears very relevant to the situation at AKU.

With regards to their theory and psychomotor skills, some supervisors compared AKU-SON graduates with non-AKU-SON nurses who are trained through the apprenticeship model. On one hand, the supervisors felt it challenging to work with non-AKU-SON nurses because of their weak theoretical preparation, on the other hand, they felt that AKU-SON nurses were not as good as non-AKU-SON in terms of skills performance. In other words they affirmed the expectation that nursing services expect the graduates to be equally good in theory and practical skills at the entry-level (Cowin &

Hengstberger-Sims, 2006; Goode & Williams, 2004; Lowry et al., 2000). Although the supervisors acknowledged that BScN graduates are faster in acclimatizing to their work unit compared with diploma graduates, they wished to see BScNs further improved.

The supervisors' narratives reveal that although they had some understanding about the transition of nursing student to staff role, they desire to minimize this transition period as much as possible because they are pressured to fill their vacancies due to high turnover rates of RNs. Moreover, like in other parts of the world, AKU-SON aims to prepare its BScN graduates with a broad knowledge base in a variety of patient care settings instead of emphasizing on any specialty area, such as oncology, critical care, orthopedics, cardiology, and high-risk obstetrics (Goode & Williams, 2004). However, as evident in the narrative of supervisors and graduates in this study, nursing management at AKUH expect the BScN nurses to work efficiently in all areas of hospitals including specialties at entry-level. Consequently, too much is expected too soon from the BScN graduates, which in itself is a key factor for high turnover rate among new nurses (Beecroft et al., 2006; Gardner, 1992; Hurst & Koplin-Baucum, 2003; Roberts et al., 2004). Hence, I agree with Ramritu and Barnard (2001) that nurse leaders need to set realistic goals as to what to expect from a new a graduate.

With regards to minimizing the graduates' transition from student to staff role, several informants recognized the potential of a senior elective in the program. However, they also identified the drawbacks of this course in its present form including the duration of the course (25 work shifts) as well as the required theoretical assignments that consequently reduce the available time for hands-on practice. In describing the advantages of senior practicum in professional education for BScNs, Bryant and Williams (2002) noted that through this course, in addition to the opportunity of refining psychomotor skills, the students were able to develop time management and organizational skills as they gradually increased the number of patients they cared for during their shift. In addition to objectives and structure of the senior elective at AKU-SON, the graduates as well as the organization may not fully benefit if [illegible] student upon graduation is not necessarily assigned to the same unit where they do their electives. Hence, I agree with the informants' suggestion that some review of this course with collaboration between school and services may improve the effectiveness of this course for its intended goal.

Several supervisors and some graduates felt that BScN students have limited opportunity to work in critical care areas; hence, in their role as entry-level staff nurse they are not adequately prepared to care for critical patients. They proposed that BScN students need to spend more time in critical care areas, which they thought would give the students more opportunity to integrate theory into practice, including hands-on practice, and consequently enhance their comfort when they begin working as entry-level nurses. However, one must carefully consider the practicality of this suggestion from the perspective not only of a change in the BScN curriculum and required resources to implement this suggestion, but also of the possible consequences of this change for graduates' attitude towards working on general units.

The findings reveal that graduates already seem to prefer to work on critical care rather than on general units. Based on the BScN graduates' views in this study, critical care areas are different from general units in terms of not only patient acuity, but also the entire context, including nurses' roles and responsibilities, role autonomy, the nurse-physician relationship, and the organization of work; that is, team nursing versus holistic nursing. Perhaps the organization of patient care on a critical care unit may not be as challenging because of the nurse-patient ratio, but it is crucial for success on general units. If graduates are given more exposure to critical care and then work on a general unit, how would they feel about and cope with the requirements of general units? Moreover, nursing management must carefully consider the possible implications for the distribution of staff in nursing services at AKUH.

Most of the supervisors recommended improvement in the areas of professional commitment, work ethics, interpersonal skills, and attitude towards bedside nursing. Even though, in general, the supervisors recognized BScN graduates' competence and positive effect on patient care, they had mixed views on their actual contributions to patient care because of the high turnover. Some supervisors also advised enhancing the graduates' commitment to the organization—and the profession. Although educators at AKU-SON must consider this suggestion ardently, research in this topic suggests that nurses' intent to stay in an organization or in the profession is influenced by their job satisfaction, particularly their initial experiences as staff nurses (Cassells et al., 1986; Cowin & Hengstberger-Sims, 2006; McCloskey & McCain, 1987; Roberts et al., 2004). It is worth noting here that the turnover rate of medical graduates (Shafqat & Zaidi, 2007), and diploma nurses (described earlier in Chapter Five) at AKU is also high, but based on information in this study, it appears that the high turnover rate is more frequently associated with BScN graduates than other graduates at Aga Khan University.

The high mobility among BScN nurses is not unique to AKUH, but an international phenomenon. The reported turnover rate among new graduates within their first year of employment in western countries is between 35-60 % (Altier & Krsek, 2006; Beecroft et al., 2001; Halfer & Graf, 2006). In a follow-up study of 432 BScN nurses after one year in nursing practice, Cassells and colleagues (1986) reported that only two thirds of the graduates continued in their first position, whereas 28% joined a second position, and 3% worked in more than two positions. These researchers reported that one third of those who changed positions were dissatisfied with their initial employment. The two main reasons for their dissatisfaction were the lack of opportunity for promotion and advancement and the staffing patterns, which was also repeatedly verbalized by the graduates in this study.

Roberts et al. (2004) reported that graduates' experience in their first nursing position plays an important role in shaping their perceptions of nursing's role in health care delivery and professional growth opportunities, which consequently affects their job satisfaction as well as their intent to stay in the position or in nursing as a career. Because of their cross-sectional quantitative design, Roberts and colleagues were not sure whether new nurses' intent to leave actually affected their turnover rate. However, evidence in this study reveals that dissatisfied new graduates such as Aisha, Areeb, Daud, and Hamid acted on their intent within the first year in their first position.

Despite some exceptions, as discussed above, the accounts of the informants in this study suggest a positive perception of the BScN program. Similar to the writings of DeBack & Mentkowski (1986) and Poster et al. (2005), most supervisors recognized the advantages of the BScN program over the diploma program and affirmed the expected broader abilities of BScN graduates. They viewed the BScN program as a faster route to professional development for nurses. Some informants, particularly supervisors, indicated that the higher quality of candidates in the BScN program helps to produce a better calibre of nurses with comparatively less effort on the part of nurse educators. Most of the informants contended that a BScN degree for entry to practice is more appropriate to address the fast-changing needs of society as well as to enhance the professional image of nurses and nursing as a profession.

In general, the supervisors suggested that perhaps BScN graduates have the potential to engage in a variety of nursing roles besides staff nurse, but they are not being utilized fully. They highlighted various challenges in this regard, including the shortage of staff, high workload, lack of an enabling environment, and current organizational policies. These challenges were not only preventing the effective utilization of BScN graduates, but, as with other nurses, affecting their job satisfaction at AKUH (Khowaja et al., 2005) and consequently resulting in a high turnover rate, which from the supervisors' perspective is a major reason for the ineffective utilization of BScNs. To attract and retain new graduates, an increasing number of hospitals in North America are focusing on facilitating new graduates during their transition period through offering better mentorship or residency programs (Goode & Williams, 2004), defining the quality of nurses' work life (Brooks & Anderson, 2005), and addressing the issues that nurses face in their work environment (Armstrong & Laschinger, 2006; Lake, 2002) such as staffing and resource adequacy, nurse managers' ability to lead and support nurses, and the nurse-physician relationship.

The graduates were dissatisfied with their salary and working conditions. Several will not leave the profession, but are planning to emigrate. Kline (2003) noted that higher wages and better working conditions are two key factors in nurses' decision to migrate from their native countries. Kline asserted, "Migration is predicted to continue until developed countries address the underlying causes of nurse shortages and until developing countries address conditions that cause nurses to leave" (p. 107). Hence it is time for AKU to address the issue of its nurses' work environment in a comprehensive manner and, as with its role in nursing education, to set an example for other organizations in the country to improve nurses' work environment.

## Recommendations

The recommendations listed below include views of the participants as well as my own. Some of these recommendations are specific to AKU-SON and AKUH, whereas others apply to AKU in general. In addition, I have included recommendations for nurse leaders and suggested areas for further research.

### *AKU-SON*

1. Nurse leaders at AKU, whether faculty members or clinicians, need to develop a shared philosophy of nursing. Collaboration between AKU-SON and AKUH requires enhancement, and it must extend beyond the representation of members on each other's committees. Ardent communication between nurse educators and clinical staff is important to develop joint ownership of nursing at AKU.

2. In light of the participants' suggestions, the goals of the BScN program should be reviewed. A list of expected general competencies for BScN at the entry level should be determined. A joint committee involving representatives of the school, services, and BScN graduates should consider the feasibility of each suggestion for program improvement, such as course sequencing, policies regarding students' clinicals, objectives, and the structure of the senior practicum.

3. The list of psychomotor and technical skills that are taught in the program should be reviewed and prioritized to ensure that more emphasis is given to the most needed skills.

4. The course faculty must be very vigilant about the differences in their learning needs when offering combined classes to students from different programs.

5. In view of the identified misperception of the career progression of BScNs, nursing faculty members should be aware of this issue and avoid messages that may be misinterpreted. A session on this topic at the beginning and towards the end of the program would be useful.

6. To increase the comfort of male students and to address the perception of reversed gender discrimination, an active effort should be made to recruit male teachers in the faculty of nursing.

7. To enhance the culture of academic writing among nurses, the school should take a lead in establishing a nursing journal.

8. The quality of the data on graduates from all nursing programs needs urgent attention. Such data are crucial in making strategic decisions based on facts rather than perceptions. A better recordkeeping system will help to obtain an accurate picture of the turnover on an ongoing basis and to monitor the effect of strategies that may be in place to minimize the turnover.

9. The recruitment strategies used in the nursing program at AKU-SON must be reviewed carefully to attract candidates who are well informed about the reality of nursing work before they decide to join nursing.

10. AKU-SON should prepare a plan to phase out the diploma program.

### *AKUH*

1. Nursing management should have realistic expectations of new graduates. The transition from a student to a staff role is a developmental stage in nurses' careers regardless from which program they graduate. This developmental stage cannot be skipped; however, various strategies could be used to minimize the known stressors of this stage. Strategies, such as those already recommended by Lalani (2005), if implemented will lead to faster and more effective adaptation of graduates to their new role instead of feeling alienated from the institution or the profession.

2. The existing CBO should be implemented consistently. The current CBOs are descriptive in nature and should be reviewed with input from new graduates; patient care management issues based on case scenarios pertinent to the unit should be included in the CBOs. Similarly, content on reducing stress and enhancing self-esteem would be useful.

3. Considering the existing demands of the CNI role, particularly on the large units, other nurses with two or more years experience should be trained for preceptorship roles. Such preceptors would be useful for students in the summer and winter clinicals and to facilitate the unit-based CBO for novice nurses. Monitory incentives or access to free education should be considered for the precptors. AKU-SON and AKUH should collaborate and share the cost of a systematic preceptorship program.

4. Nurses' preferences for work units should be respected as much as possible, and they should be asked to indicate up to three areas where they do not want to work.

5. The shortage of nurses at AKUH needs ardent consideration. The percentage of novice nurses is alarming and detrimental to the quality of nursing services as well as

education. We cannot expect to have good-quality graduates without experienced teachers, mentors, and preceptors.

6. The issues that arise in the work environment, including workload, double shifts, nurses' role autonomy, the nurse-physician relationship, and supportive management practices, need urgent attention. The workload of nurses on the general unit is a major source of burnout.

7. The issue of the nursing shortage that requires double shifts is a good cause of physical and emotional exhaustion among staff nurses and is equally frustrating for the nursing management, who constantly have to adjust the staff duty schedules. Nursing services need to use other strategies to manage staff leaves rather than double shifts. For example, having a pool of part-time nurses could be helpful. A number of nurses from the other private agency could be offered some additional training and orientation at AKUH, and these nurses could be called to cover for unplanned or uninformed staff leaves.

8. AKUH must consider implementing a shift differential for nurses who work in the evening and on night shift and weekends to minimize absenteeism on these shifts.

9. Nursing management needs to develop a greater understanding of the challenges of managing the younger generation, who aspire to balance in work life and personal life and desire flexibility, continuous educational opportunities, and a good salary. Therefore, it is not wise to expect that the use of authority and power will change their work ethics; the management staff will need to adopt new ways to handle people of this generation. Hence, a change from an autocratic to a participatory leadership style would be more helpful to work successfully with this group (Sherman, 2006).

10. To acknowledge the addition of BScN nurses to the nursing workforce and to utilize their services better, nursing services should review some of their previous documents and policies, such as job descriptions, promotion policies, and career structure. The career structure should be based on consideration of nurses' education and experience, and it should be accessible on the website.

11. Disparities in salaries between different constituencies such as AKUH and AKU-SON must be explored and addressed. Similarly, AKUH must explore and address any disparities that exist between BScNs and post-RN BScN who have similar work experience.

12. As a long-term plan, AKUH should explore the separation of the male and female units. This strategy would not only demonstrate cultural sensitivity, but also help with the staffing issues identified in this study.

### *Nurse Leaders*

1. The nursing advisor at the national level, in collaboration with other national and provincial nursing forums, should chalk out a plan and implement it to raise public awareness about the importance of nursing.

2. The PNC's educational accreditation standards must emphasize continuing and higher education of teachers. A nursing school that offers a BScN program should have some master's-prepared faculty to ensure that the quality of nursing education does not deteriorate as has happened in the past when faculty with only post-basic diplomas taught the same program without further education.

3. In addition to improving the quality of nursing education in Pakistan, nurse leaders must also pay equal attention to the quality of nurses' work life.

4. With regard to effective integration and utilization of BScN graduates in the nursing workforce, nurse leaders and administrators in other institutions that have recently initiated BScN programs should capitalize on the findings of this study. Similarly, using the findings of this study, the PNC and the Higher Education Commission in Pakistan must extend their advice beyond the standards for curriculum content for baccalaureate programs to factors that influence the effective utilization of the graduates.

## Areas for Further Research

I have identified various areas for further research in this study, including the utilization and effectiveness of clinicals hours, the sociocultural characteristics of graduates and their impact on their confidence and performance, and students' experiences of performing basic care in the first year. In addition, nurses' workload seems to be a pressing issue, as this study as well as previous studies have shown. AKUH will benefit from work analysis studies for both nurses and physicians. These studies must be conducted by an external expert with a neutral perspective on these professions; however, a nurse and a physician could work as co-investigators to minimize the chances of misinterpretation and to enhance the confidence in the results. Moreover, patients' perceptions of nurses' competence, particularly communication, should be explored. Similarly, nurse-physician collaboration should be investigated from both nurses' and physicians' perspectives. Replication of the current study in other institution, particularly in the public sector will also be useful.

## Strengths and Limitations of the Study

The selected methodology used in the study—focused ethnography led me to obtain rich and comprehensive information. The acquired comparability of findings between the graduates and supervisors as well as different methods of data collection lends credence to the rigor of this study.

Being an insider with a good personal reputation at AKU, made it easier for me to gain access to information pertinent to this study. A person new to the system would have required much longer time to gain trust of the people in the system and to access that information. In addition, my experience as a nurse manager and educator made it easier for me to relate to the experience of the participants whether graduates or supervisors and this may have influenced the depth and openness of their responses to me. Likewise, my command on both languages English and Urdu allowed the participants to share their feelings freely which contributed to the richness of their narratives.

Many participants, graduates as well as supervisors expressed to the researcher that this study was very timely. On one hand this study identified strengths and limitations of the existing BScN curriculum at AKU-SON. On the other hand, this study stimulated thinking of the nursing management team at AKUH to reflect on various factors that are affecting BScN graduates' retention and utilization. Lessons learned from the experiences of BScN graduates at AKU will be useful for other nursing institution in Pakistan that have recently initiated a BScN program.

This study involved three possible limitations that might not have severely influenced the research but are worth mentioning nonetheless. First, because this study is a component of my PhD program, I was required to complete it within a certain timeframe, and the time allocated to the data collection was three to four months. Considering the contextual influence of the work environment on nurses' competence, I might have learned more through extensive participant observation that included nurses' interactions with patients; however, in view of the given timeframe for data collection in this study, I limited my participant observation to sampling the specific events detailed in the Participant Observation section of Chapter Three.

Second, in an ideal situation one would consider the input of all stakeholders, especially patients, who might have useful insights into the abilities of BScN nurses. However, eliciting direct input from patients was not feasible because they are not necessarily aware of the educational background of nurses. Therefore, this study was limited to the input of graduates and their supervisors, who were considered the most knowledgeable about the phenomenon of interest in this study. Although I recruited the graduates in this study from AKUH, AKU-SON (constituencies of AKU), and other institutions in the province of Sindh-Pakistan, I recruited all of the supervisors from only AKUH for two reasons: (a) out of 84 graduates who were working in Pakistan, 60 (almost 75%) were working in AKUH, and the rest (approximately 25%) were scattered in other places; (b) the supervisors in AKUH had the opportunity to work with more graduates than did the supervisors in other places who were supervising only one or two graduates. Hence, the concerned supervisors, other than those at AKUH, were not in a position to offer a general view of the graduates' competence, but rather their view of only individual graduates' competence which was not the goal of this study.

Third, most of the participants in this study had good or excellent English language skills; hence most of the interviews were held in English, with some exceptions as detailed in the Interviews section of Chapter Three. Translation from Urdu into English could have resulted in the loss of some of the essence or meaning of the data. However, to minimize this risk, I conducted a member check after the translation from Urdu into English.

## Final Reflections on the Findings

This is the first ethnographic study, within the context of Pakistan, to identify and describe the experiences and perceptions of competence of the BScN nurses. This study adds on to the existing body knowledge at least in three areas: description of competence in nursing, competence of nurses with baccalaureate education, and factors affecting the competence of nurses in practice. This study has provided valuable information for educators and practitioners to use in planning for nursing education in future. Although the context of this study was a developing country, its findings present striking similarities with the research findings of similar topics in developed countries which is important from the perspectives of knowledge transferability from one context to another. However, replication of this study would be advisable in other settings of Pakistan because in many aspects AKU is different than the other nursing institutions in the country.

Findings of this study affirm that the initiation of the BScN program in Aga Khan University was a step in the right direction. Informants affirmed the value of baccalaureate education for nurses at entry to practice level. Their narratives supported that BScN graduates supercede diploma graduates because of their personal and professional characteristics. BScN nurses are prepared with a range of transferable skills which enable them to engage in a variety of nursing roles besides staff nurse. In other words, goals of the BScN program have been achieved with regards to the capabilities of the graduates; however, various factors have affected full utilization of their potential.

Considering the fact that competence is a complex phenomenon that results from combination of various personal, educational, and contextual factors, the responsibility of health care leaders including nurse leaders is not fulfilled by attracting bright people into the profession and providing them with quality education, but also by providing them with an enabling environment in which the nurses are not only able to actualize their competence but which ensures continued competence for safe and holistic care to its clients.

Nursing services seems to be overwhelmed by the turnover of BScN. Although the supervisors are cognizant of the challenges of the work environment, they tend to attribute this lack of nurses retention with the graduates' attitude and commitment towards nursing. However, the graduates are dissatisfied with their salary, promotional opportunities, and work conditions; they are vocal and not willing to accept the work conditions that they do not like. Moreover, because of their degree education, they seem to have more opportunities and better prospects outside AKUH. Similarly, they have the opportunity and interest to upgrade their education faster than diploma nurses. The combination of these factors is making it difficult for nursing services to retain these nurses and create a negative perception of BScN graduates at the Aga Khan University, even though the issue of nurses' retention is not limited to BScN graduates but all graduates.

Findings of this study suggest that in introducing a new program, the nurse leaders need to focus beyond the content of curriculum and its delivery. In addition to considering what the graduates of a new program will able to do, leaders must pay attention to how they will fit in the arena of all existing health care professionals. A thorough assessment of the work environment would be fruitful to strategize about the possible impeding factors that may not allow the graduates to use their full potential.

Over the past two and a half decades, the Aga Khan University has played a significant role in setting precedence in quality of health care education to produce competent health care professionals including nurses and physicians. However, neither AKU nor other health care organizations in Pakistan can fully utilize the potential of these health care professionals if the current level of turnover statistics remains a constant. This study presents an opportunity for the Aga Khan University and particularly AKUH to reflect upon its work environment and respond creatively to the identified problems and consequently overcome the acute issue of nurses retention in the organization.

# REFERENCES

Abruzzese, R. S. (1996). *Nursing staff development: Strategies for success*. St. Louis, MO: Mosby-Year Book.

AbuAlRub, R. F. (2004). Job stress, job performance, and social support among hospital nurses. *Journal of Nursing Scholarship, 36,* 73-78.

AbuAlRub, R. F. (2006). Replication and examination of research data on job stress and coworker social support with Internet and traditional samples. *Journal of Nursing Scholarship, 38,* 200-204.

AbuGharbieh, P. & Suliman, W. (1992). Changing the image of nursing in Jordan through effective role negotiation. *International Nursing Review, 39,* 149-52, 144.

Adamczyk, R. (2006). Editorial: The nursing education paradigm and beyond: Linking theory to practice. *Nurse Education in Practice, 6,* 183-184.

Agar, M. (1980). *The professional stranger*. New York: Academic Press.

Aiken, L. H., Clarke, S. P., Cheung, R. B., Sloane, D. M., & Silber, J. H. (2003). Educational levels of hospital nurses and surgical patient mortality. *Journal of the American Medical Association, 290,* 1617-1623.

Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J. A., Busse, R., Clarke, H. et al. (2001). Nurses' reports on hospital care in five countries: The ways in which nurses' work is structured have left nurses among the least satisfied workers, and the problem is getting worse. *Health Affairs, 20*(3), 43-53.

Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J. A., & Silber, J. H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of the American Medical Association, 288*(16), 1987-1993.

Aiken, L. H., & Sloane, D. M. (1997). Effects of specialization and client differentiation on the status of nurses: The case of AIDS. *Journal of Health and Social Behavior, 38,* 203-222.

Alavi, C., Loh, S. H., & Reilly, D. (1991). Reality basis for teaching psychomotor skills in a tertiary nursing curriculum. *Journal of Advanced Nursing, 16,* 957-965.

Alexander, C. S., Weisman, C. S., & Chase, G. A. (1982). Determinants of staff nurses' perceptions of autonomy within different clinical contexts. *Nursing Research, 31,* 48-52.

Alfaro-LeFevre, R. (2002). *Applying nursing process: Promoting collaborative care.* (5th ed.) Philadelphia: Lippincott.

Ali, N. S. (1996). Providing culturally sensitive care to Egyptians with cancer. *Cancer Practice, 4,* 212-215.

Altier, M. E., & Krsek, C. A. (2006). Effects of a 1-year residency program on job satisfaction and retention of new graduate nurses. *Journal for Nurses in Staff Development, 22,* 70-77.

Amarsi, Y. (2003). Nursing health human resources in Pakistan. In N. H. Bryant (Ed.), *Women in nursing in Islamic societies* (pp. 188-231). New York: The Oxford University Press.

Armstrong, K. J., & Laschinger, H. (2006). Structural empowerment, Magnet hospital characteristics, and patient safety culture: making the link. *Journal of Nursing Care Quality, 21,* 124-134.

Arthur, D., Sohng, K. Y., Noh, C. H., & Kim, S. (1998). The professional self concept of Korean hospital nurses. *International Journal of Nursing Studies, 35,* 155-162.

Ashworth, P. D., Gerrish, K., Hargreaves, J., & McManus, M. (1999). 'Levels' of attainment in nursing practice: Reality or illusion? *Journal of Advanced Nursing, 30,* 159-168.

Australian Nursing and Midwifery Council. (2002). *National competency standard for the registered nurse and the enrolled nurse.* Retrieved November 10, 2004, from http://www.anmc.org.au/website/National%20Standards/RN%20&%20EN%20Competency%20Standards/RN&ENcompetencies.pdf

Baggs, J. G., Schmitt, M. H., Mushlin, A. I., Mitchell, P. H., Eldredge, D. H., Oakes, D. et al. (1999). Association between nurse-physician collaboration and patient outcomes in three intensive care units. *Critical Care Medicine, 27,* 1991-1998.

Bartlett, H. P., Simonite, V., Westcott, E., & Taylor, H. R. (2000). A comparison of the nursing competence of graduates and diplomates from UK nursing programmes. *Journal of Clinical Nursing, 9,* 369-379.

Battersby, D. & Hemmings, L. (1991). Clinical performance of university nursing graduates. *Australian Journal of Advanced Nursing, 9,* 30-34.

Beach, D. J. (2002). Professional knowledge and its impact on nursing practice. *Nurse Education in Practice, 2*(2), 80-86.

Beecroft, P. C., Kunzman, L., & Krozek, C. (2001). RN internship: outcomes of a one-year pilot program. *Journal of Nursing Administration, 31,* 575-582.

Beecroft, P. C., Santner, S., Lacy, M. L., Kunzman, L., & Dorey, F. (2006). New graduate nurses' perceptions of mentoring: six-year programme evaluation. *Journal of Advanced Nursing, 55,* 736-747.

Beeken, J. E. (1997). The relationship between critical thinking and self-concept in staff nurses and the influence of these characteristics on nursing practice. *Journal of Nursing Staff Development, 13*(5), 272-278.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison Wesley.

Benner, P., & Benner, R. V. (1979). *The new nurses' work entry: A troubled sponsorship* New York: The Tiresias.

Benner, P., Tanner, C. A., & Chesla, C. A. (1996a). Clinical judgment. In P. Benner, C. A. Chesla, & C. A. Tanner (Eds.), *Expertise in nursing practice: Caring, clinical judgment and ethics* (pp. 1-28). New York: Springer.

Benner, P., Tanner, C. A., & Chesla, C. A. (1996b). *Expertise in nursing practice: Caring, clinical judgment and ethics*. New York: Springer.

Bernard, H. R. (1988). *Research Methods in cultural anthropology*. Newbury Park, CA: Sage.

Bjork, I. T. (1999a). Practical skill development in new nurses. *Nursing Inquiry, 6,* 34-47.

Bjork, I. T. (1999b). What constitutes a nursing practical skill? *Western Journal of Nursing Research, 21,* 51-63.

Bjork, I. T., & Kirkevold, M. (1999). Issues in nurses' practical skill development in the clinical setting. *Journal of Nursing Care Quality, 14,* 72-84.

Boggs, D., Baker, B., & Price, G. (1987). Determining two levels of nursing competency. *Nursing Outlook, 35,* 34-37.

Boyle, D. K., Popkess-Vawter, S., & Taunton, R. L. (1996). Socialization of new graduate nurses in critical care. *Heart Lung, 25,* 141-154.

Boyle, J. (1994). Style of ethnography. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 159-185). Thousand Oaks, CA: Sage.

Bradshaw, A. (1997). Defining "competency" in nursing (part I): A policy review. *Journal of Clinical Nursing, 6*(5), 347-354.

Bradshaw, A. (1998). Defining 'competency' in nursing (part II): An analytical review. *Journal of Clinical Nursing, 7*(2), 103-111.

Bradshaw, A. (2000). Editorial... competence in the practicalities of caring for patients. *Journal of Clinical Nursing, 9*(3), 319-320.

Brasler, M. E. (1993). Predictors of clinical performance of new graduate nurses participating in preceptor orientation programs. *Journal of Continuing Education in Nursing, 24,* 158-165.

Brink, P. J., & Edgecombe, N. (2003). What is becoming of ethnography? *Qualitative Health Research, 13,* 1028-1030.

Brink, P. J., & Wood, M. J. (2001). *Basic steps in planning research: From question to proposal.* (5th ed.) Sudbury, Massachusetts: Jones and Bartlett.

Brooks, B. A., & Anderson, M. A. (2005). Defining quality of nursing work life. *Nursing Economics, 23,* 319-326.

Bryant, N. H. (2003). Introduction. In N. H. Bryant (Ed.), *Women in nursing in Islamic societies* (pp. 1-13). New York: Oxford University Press.

Bryant, S., & Williams, D. (2002). The Senior Practicum. *Nurse Educator, 27,* 174-177.

Buchan, J. (2001). Nurse migration and international recruitment. *Nursing Inquiry, 8,* 203-204.

Buller, S., & Butterworth, T. (2001). Skilled nursing practice—a qualitative study of the elements of nursing. *International Journal of Nursing Studies, 38,* 405-417.

Bullough, B., & Sparks, C. (1975). Baccalaureate vs associate degree nurses: The care-cure dichotomy. *Nursing Outlook, 23,* 688-692.

Burke, L. M., & Harris, D. (2000). Education purchasers' views of nursing as an all graduate profession. *Nurse Education Today, 20,* 620-628.

Burns, N., & Grove, S. K. (1997). *The practice of nursing research: Conduct, critique & utilization.* (3rd ed.) Philadelphia: Saunders.

Calhoun, S. K. (2005). Generations at work. *Journal of the America Association of Occupational Health Nurses, 53,* 469-471.

Campbell, B., & Mackay, G. (2001). Continuing competence: An Ontario nursing regulatory program that support nurses and employers. *Nursing Administration Quarterly, 25*(20), 22-30.

Carlowe, J. (1998). Value nurses and they will stay. *Nursing Standards, 12,* 12-13.

Casey, K., Fink, R., Krugman, M., & Propst, J. (2004). The graduate nurse experience. *Journal of Nursing Administration, 34,* 303-311.

Cassells, J. M., Redman, B. K., & Jackson, S. S. (1986). Generic baccalaureate nursing student satisfaction regarding professional and personal development prior to graduation and one year post graduation. *Journal of Professional Nursing, 2,* 114-127.

Cathcart, E. B. (2003). Using the NCLEX-RN to argue for BSN preparation: Barking up the wrong tree. *Journal of Professional Nursing, 19,* 121-122.

Chornick, N. L. (1992). A comparison of RN-to-BSN completion graduates to generic BSN graduates: Is there a difference? *Journal of Nursing Education, 31,* 203-209.

Cline, D., Reilly, C., & Moore, J. F. (2004). What's behind RN turnover? Uncover the "real reason" nurses leave. *Holistic Nursing Practice, 18,* 45-48.

Clinton, M., Murrells, T., & Robinson, S. (2005). Assessing competency in nursing: A comparison of nurses prepared through degree and diploma programmes. *Journal of Clinical Nursing, 14,* 82-94.

College and Association of Registered Nurses of Alberta. (2005). Nursing practice standards. Edmonton, AB: Author

College and Association of Registered Nurses of Alberta. (2006). Entry-to-practice competencies for the registered nurses profession. Edmonton, AB: Author.

Committee for the Study of Nursing Education (1923). *Nursing and nursing education in the United States* New York: The Macmillan Company.

Cowin, L. S., & Hengstberger-Sims, C. (2006). New graduate nurse self-concept and retention: A longitudinal survey. *International Journal of Nursing Studies, 43,* 59-70.

Creswell, J. W. (1994). *Research design: Qualitative and quantitative approaches.* Thousand Oaks, CA: Sage.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks, CA: Sage.

Cruickshank, J. F., MacKay, R. C., Matsuno, K., & Williams, A. M. (1994). Appraisal of the clinical competence of registered nurses in relation to their designated levels in the Western Australian nursing career structure. *International Journal of Nursing Studies, 31,* 217-230.

DeBack, V., & Mentkowski, M. (1986). Does the baccalaureate make a difference?: differentiating nurse performance by education and experience. *Journal of Nursing Education, 25*(7), 275-285.

del Bueno, D. J., Weeks, L., & Brown-Stewart, P. (1987). Clinical assessment centers: A cost-effective alternative for competency development. *Nursing Economics, 5,* 21-26.

Dennis, L. C., & Janken, J. K. (1979). *The relationship between nursing education and performance: A critical review* (DHEW Publication No. HRA 79-38). Washington, DC: Medicus Systems.

Denzin, N. K. (1978). *Sociological methods: A source book*. New York : McGraw Hill.

Di Vito-Thomas, P. (2000). Identifying critical thinking behaviors in clinical judgments. *Journal for Nurses in Staff Development, 16,* 174-180.

Doran, D. I., Sidani, S., Keatings, M., & Doidge, D. (2002). An empirical test of the Nursing Role Effectiveness Model. *Journal of Advanced Nursing, 38,* 29-39.

Dozier, A. M. (1998). Professional standards: Linking care, competence, and quality. *Journal of Nursing Care Quality, 12,* 22-29.

Drach-Zahavy, A. (2004). Primary nurses' performance: Role of supportive management. *Journal of Advanced Nursing, 45,* 7-16.

Dreher, M. (1994). Qualitative research methods from the reviewer's perspective. In J. M. Morse (Ed.), *Critical Issues in qualitative research methods* (pp. 281-297). Thousand Oaks: Sage.

Duchscher, J. E. B. (2001). Out in the real world: Newly graduated nurses in acute-care speak out. *Journal of Nursing Administration, 31,* 426-439.

Duchscher, J. E. B., & Cowin, L. (2004). Multigenerational nurses in the workplace. *Journal of Nursing Administration, 34,* 493-501.

Elkan, R., & Robinson, J. (1993). Project 2000: The gap between theory and practice. *Nurse Education Today, 13,* 295-298.

Ellis, R. (1988). *Professional competence and quality assurance in the caring professions*. London, UK: Chapman Hall.

Engineer, A. A. (2004). State of women's rights in Muslim countries. *DAWN*, Retrieved, November 20, 2004 from: http://www.dawn.com/weekly/encounter/encounter.htm#3

Epstein, R. M., & Hundert, E. M. (2002). Defining and assessing professional competence. *Journal of the American Medical Association, 287,* 226-235.

Eraut, M. (1994). *Developing professional knowledge and competence*. London, UK: Falmer Press.

Eraut, M. (1998). Concepts of competence. *Journal of Interprofessional Care, 12,* 127-139.

Ervin, N. E. (2006). Does patient satisfaction contribute to nursing care quality? *Journal of Nursing Administration, 36,* 126-130.

Fearon, M. (1998). Assessment and measurement of competence in practice. *Nursing Standards, 12,* 43-47.

Ferguson, L. M. (2006). *Developing competence in clinical judgment*. Unpublished doctoral dissertation, University of Alberta. Edmonton, AB.

Ferguson, L. M., & Day, R. A. (2007). Challenges for new nurses in evidence-based practice. *Journal of Nursing Management, 15,* 107-113.

Fetterman, D. M. (1989). *Ethnography: Step by step*. Newbury Park, CA : Sage.

Field, P. A. (1978). *A follow- up study of graduates from the four year B.Sc. programme in nursing*. University of Alberta. Edmonton, AB: University of Alberta.

Field, P. A. (1983). An ethnography: Four public health nurses' perspectives of nursing. *Journal of Advanced Nursing, 8,* 3-12.

Field, P. A. (1991). Doing Field work in your own culture. In J. M. Morse (Ed.), *Qualitative nursing research: A contemporary dialogue* (2nd ed., pp. 91-104). Newbury Park: Sage.

Fikree, F. F., Khan, A., Kadir, M. M., Sajan, F., & Rahbar, M. H. (2001). What influences contraceptive use among young women in urban squatter settlements of Karachi, Pakistan? *International Family Planning Perspectives, 27,* 130-136.

Finn, C. P. (2001). Autonomy: An important component for nurses' job satisfaction. *International Journal of Nursing Studies, 38,* 349-357.

Fisher, M., & Parolin, M. (2000). The reliability of measuring nursing clinical performance using a competency based assessment tool: A pilot study. *Collegian. 7,* 21-27.

Floyd, J. M. (2001). Envisioning new nursing roles and scopes of practice. *Reflections on Nursing Leadership, 27,* 52-3, 45.

Foley, B. J., Kee, C. C., Minick, P., Harvey, S. S., & Jennings, B. M. (2002). Characteristics of nurses and hospital work environments that foster satisfaction and clinical expertise. *Journal of Nursing Administration, 32,* 273-282.

Fosbinder, D. (1994). Patient perceptions of nursing care: An emerging theory of interpersonal competence. *Journal of Advanced Nursing, 20,* 1085-1093.

French, S. E. (1991). *Assessment of Human Resources Component of the Family Health Project.* Ottawa: CIDA Asian Branch, Pakistan Program.

French, S. E., Watters, D., & Matthews, D. R. (1994). Nursing as a career choice for women in Pakistan. *Journal of Advanced Nursing, 19,* 140-151.

Furrukh, Z. (1962). *Factors involved in dissatisfaction of the nurses with their Profession.* Unpublished Master Thesis University of Punjab, Pakistan.

Gale, L. E., & Pol, G. (1975). Competence: A definition and conceptual Scheme. *Educational Technology, 15,* 19-25.

Gardner, D. L. (1992). Conflict and retention of new graduate nurses. *Western Journal of Nursing Research, 14,* 76-85.

Garland, G. A. (1996). Self report of competence. A tool for the staff development specialist. *Journal of Nursing Staff Development, 12,* 191-197.

Germain, C. (1986). Ethnography: The method. In P.L. Munhall & C. J. Oiler (Eds.), *Nursing Research: A qualitative perspective* (pp. 147-162). Norwalk, Connecticut: Appleton-Century-Crofts.

Gibbon, B. (1995). Validity and reliability of assessment tools. *Nurse Researcher, 2*(4), 48-55.

Gillis, A., & Jacson, W. (2002). *Research for nurses: Methods and interpretation.* Philadelphia: F. A. Davis.

Girot, E. A. (1993a). Assessment of competence in clinical practice: A phenomenological approach. *Journal of Advanced Nursing, 18*, 114-119.

Girot, E. A. (1993b). Assessment of competence in clinical practice: A review of the literature. *Nurse Education Today, 13,* 83-90.

Girot, E. A. (2000a). Assessment of graduates and diplomates in practice in the UK: Are we measuring the same level of competence? *Journal of Clinical Nursing, 9*(3), 330-337.

Girot, E. A. (2000b). Graduate nurses: Critical thinkers or better decision makers? *Journal of Advanced Nursing, 31,* 288-297.

Godin, M. M. (1996). *Faculty, employer, and client perspective of clinical competence in community-based health care.* Abstract retrieved April 26, 2004 from CINAHL database.

Godinez, G., Schweiger, J., Gruver, J., & Ryan, P. (1999). Role transition from graduate to staff nurse: A qualitative analysis. *Journal for Nurses in Staff Development, 15,* 97-110.

Gonczi, A. (1994). Competency-based assessment in the professions in Australia. *Assessment in Education, 1,* 27-44.

Goode, C. J., Pinkerton, S., McCausland, M. P., Southard, P., Graham, R., & Krsek, C. (2001). Documenting chief nursing officers' preference for BSN-prepared nurses. *Journal of Nursing Administration, 31,* 55-59.

Goode, C. J., & Williams, C. A. (2004). Post-baccalaureate Nurse Residency Program. *Journal of Nursing Administration, 34,* 71-77.

Goodwin, J. (1995). *Price of honour*. London: Warner Books.

Gortner, S. R. (1999). Nursing values and science: Towards a science philosophy. In E. C. Polifroni & M. Welch (Eds.), *Perspectives on philosophy of science in nursing* (pp. 25-33). Philadelphia: Lippincott.

Gosnell, D. (2002). The 1965 entry into practice proposal – is it relevant today? *Online Journal of Issues in Nursing*, 7 (2). Retrieved March 24, 2004, from: http://www.nursingworld.org/ojin/topic18/tpc18ntr.htm

Gould, M. (1999). Universities want all graduate profession. *Nursing Standards, 12,* 7.

Gray, J. E., Murray, B. L., Roy, J. F., & Sawyer, J. R. (1977). Do graduates of technical and professional nursing programs differ in practice? *Nursing Research, 26,* 368-373.

Greenwood, J. (2000). Critique of the graduate nurse: An international perspective. *Nurse Education Today, 20,* 17-23.

Guba, E. G., & Lincoln, Y. S. (1981). *Effective evaluation: Improving the usefullness of evaluation results through responsive and naturalistic approaches.* San Francisco, CA: Jossey-Bass.

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Newbury Park, CA: Sage.

Gul, R. (1998). *The image of nursing from nurses and non-nurses' perspectives in a Pakistani society.* Unpublished Master's Thesis. University of New South Wales, NSW, Australia.

Gurvis, J. P., & Grey, M. T. (1995). The anatomy of a competency. *Journal of Nursing Staff Development, 11,* 247-252.

Haddad, L., Al-Mohandis, B., & Mughal, I. (2005). *External evaluation report: The Aga Khan University School of Nursing* Karachi, Pakistan: The Aga Khan University.

Halfer, D., & Graf, E. (2006). Graduate nurse perceptions of the work experience. *Nursing Economics, 24,* 150-5, 123.

Halstead, J.S., Rains, J.W., Boland, D.L., & May, F.E. (1996). Reconceptualizing baccalaureate nursing education: Outcomes and competencies for practice in the 21st century. *Journal of Nursing Education, 35* (9), 413-416.

Hammersley, M., & Atkinson, P. (1995). *Ethnography: Principles in practice.* (2nd ed.) London: Routledge.

Harnar, R., Amarsi, Y., Herberg, P., & Miller, G. (1992). Health and nursing services in Pakistan: problems and challenges for nurse leaders. *Nursing Administration Quarterly, 16,* 52-59.

Hayter, J. (1971). Follow-up study of graduates of the University of Kentucky, College of Nursing, 1964-1969. *Nursing Research, 20,* 55-60.

Hemani, H. (2003). *History of nursing in Pakistan*. Peshawar, Pakistan: National Nursing Text Book Board.

Henderson, S. (2002). Factors impacting on nurses' transference of theoretical knowledge of holistic care into clinical practice. *Nurse Education in Practice, 2,* 244-250.

Horsburgh, M. (1989). Graduate nurses' adjustment to initial employment: Natural field work. *Journal of Advanced Nursing, 14,* 610-617.

Howard, E., Hubelbank, J., & Moore, P. (1989). Employer evaluation of graduates: Use of the focus group. *Nurse Educator, 14,* 38-41.

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15,* 1277-1288.

Hurst, S., & Koplin-Baucum, S. (2003). Role acquisition, socialization, and retention: Unique aspects of a mentoring program. *Journal for Nurses in Staff Development, 19,* 176-180.

Inoue, M., Chapman, R., & Wynaden, D. (2006). Male nurses' experiences of providing intimate care for women clients. *Journal of Advanced Nursing, 55,* 559-567.

International Council for Nurses (2003). Global issues in the supply and demand of nurses. Retrieved December 11, 2004, from: http://www.icn.ch/sewjan-marh03.htm

Irvine, D., Leatt, P., Evans, M. G., & Baker, R. G. (1999). Measurement of staff empowerment within health service organizations. *Journal of Nursing Measurement, 7,* 79-96.

Irvine, D., Sidani, S., & Hall, L. M. (1998). Linking outcomes to nurses' roles in health care. *Nursing Economics, 16,* 58-64, 87.

Jasper, M. (1996). The first year as a staff nurse: The experiences of a first cohort of Project 2000 nurses in a demonstration district. *Journal of Advanced Nursing, 24,* 779-790.

Johnson, J. H. (1988). Differences in the performances of baccalaureate, associate degree, and diploma nurses: A meta-analysis. *Research in Nursing & Health, 11,* 183-197.

Joyce-Nagata, B., Reeb, R., & Burch, S. (1989). Comparison of expected and evidenced baccalaureate degree competencies. *Journal of Nursing Education, 28,* 314-321.

Kangas, S., Kee, C. C., & McKee-Waddle, R. (1999). Organizational factors, nurses' job satisfaction, and patient satisfaction with nursing care. *Journal of Nursing Administration, 29,* 32-42.

Kanji, Z., & Stanley, G. (2001). Survey of registered nurses in Pakistan with university degrees. University of Toronto - McMaster University, Nursing effectiveness, Utilization & Outcome Research Unit. Working Paper 01-2.

Kanji, Z., Virani, M., Pirani, L., Sumar, F., Rahmatulla, S., & Sergeant, D. (2001). A pilot study: Work of nursing personnel in a government hospital in the province of Sindh, Pakistan. Nursing effectiveness, Utilization & Outcome Research Unit. 1-37. University of Toronto-McMaster University. Working Paper Series 01-1.

Kapborg, I., & Fischbein, S. (2002). Using a model to evaluate nursing education and professional practise. *Nursing and Health Sciences, 4,* 25-31.

Katz, J. M. (1992). Managing the dual dimension of quality. In R. S. Abruzzese (Ed.), *Nursing staff development: Strategies for success* (pp. 293-316). St. Louis: Mosby.

Khan, K. S. (2003). Women of Pakistan: Trapped but struggling. In N. H. Bryant (Ed.), *Women in nursing in Islamic societies* (pp. 159-174). New York: Oxford University Press.

Khan, M. (1986). Women in Pakistan. *ISIS International Women's Journal, 5(2),* 41-48.

Khan, R., Gul, R., & Khan, K. (2000). *Health Sector Review in Pakistan.* Islamabad, Pakistan: Canadian International Development Agency, Program Support Unit.

Khowaja, K., Merchant, R. J., & Hirani, D. (2005). Registered nurses perception of work satisfaction at a Tertiary Care University Hospital. *Journal of Nursing Management, 13,* 32-39.

Khowaja, K., & Nensey, R. (1999). Retention and turnover at AKUH. *The Nurse International, 1,* 12-15.

Khoza, L. B., & Ehlers, V. J. (1998). The competencies of newly qualified nurses as viewed by senior professional nurses. *Curationis: South African Journal of Nursing, 21*(3), 67-76.

Kikuchi, A., & Harada, T. (1997). The relationship between professional autonomy and demographic and psychological variables in nursing. *Kango Kenkyu, [In Japanese], 30,* 23-35.

Kikuchi, J. F. (2003). Nursing theories: Relic or stepping stone? *Canadian Journal of Nursing Research, 35,* 3-7.

Kim, H. S. (2000). *The nature of theoretical thinking in nursing.* (2nd ed.) New York: Springer.

Kinnear, J. l. (1994). The Professionalization of Canadian Nursing, 1924-32: Views in the CN and the CMAJ. CBMH/BCHM. Retrieved November 18, 2005, from: http://www.cbmh.ca/archive/00000290/01/cbmhbchm_v11n1kinnear.pdf

Kleinman, C. (2004). Understanding and capitalizing on men's advantages in nursing. *Journal of Nursing Administration, 34,* 78-82.

Kline, D. S. (2003). Push and pull factors in international nurse migration. *Journal of Nursing Scholarship, 35,* 107-111.

Kohnke, M. F. (1973). Do nursing educators practice what is preached? *American Journal of Nursing, 73,* 1571-1573.

Kramer, M. (1974). *Reality shock.* St. Louis, MO: Mosby Co.

Krugman, M., & Preheim, G. (1999). Longitudinal evaluation of professional nursing practice redesign. *Journal of Nursing Administration, 29,* 10-20.

Kueng, P. (2000). Process performance measurement system: A tool to support process-based organization. *Total Quality Management, 11,* 67-85.

Lake, E. T. (2002). Development of the practice environment scale of the Nursing Work Index. *Research in Nursing &Health, 25,* 176-188.

Lalani, N. S. (2005). *The process of role transition from student to staff among the nurses of a university teaching hospital in Pakistan.* Unpublished master's thesis, Aga Khan University School of Nursing, Karachi, Pakistan.

Lawler, T. G., & Rose, M. A. (1987). Professionalization: A comparison among generic baccalaureate, ADN, and RN/BSN nurses. *Nurse Educator, 12,* 19-22.

LeCompte, M. D., & Preissle, J. (1993). *Ethnography and qualitative design in educational research.* (2nd ed.) San Diego: Academic Press.

Lee, M. B., & Saeed, I. (2001). Oppression and horizontal violence: The case of nurses in Pakistan. *Nursing Forum, 36,* 15-24.

Leibbrandt, L., Brown, D., & White, J. (2005). National comparative curriculum evaluation of baccalaureate nursing degrees: A framework for the practice based professions. *Nurse Education Today, 25,* 418-429.

Leininger, M. (1994). Evaluation criteria and critique of qualitative research studies. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 95-115). Thousand Oaks, CA: Sage.

Lin, M. C., & Chen, C. H. (2004). An investigation on the nursing competence of southern Taiwan nurses who have passed N3 case report accreditation. *Journal of Nursing Research, 12,* 203-212.

Lindeman, C. (1996). A vision for nursing education. *Creative Nursing, 2,* 5-8.

Lipson, J. G. (1994). Ethical Issues in Ethnography. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 333-355). Thousand Oaks: Sage.

Liu, M. (2004). *Development of Competency Inventory for Professional Nurses (CIPN) in the People's Republic of China.* Unpublished Doctoral dissertation Graduate School of Chiang Mai University, Chiang Mai, Thailand.

Lowry, J. S., Timms, J., & Underwood, D. G. (2000). From school to work: Employer perceptions of nursing skills. *Journal for Nurses in Staff Development, 16,* 80-85.

Mancino, D. J. (2005). Professional associations. In K. K. Chitty (Ed.), *Professional nursing: Concepts and challenges* (4th ed., pp. 105-134). St. Louis: Elsevier Saunders.

Manley, K., & Garbett, R. (2000). Paying Peter and Paul: Reconciling concepts of expertise with competency for a clinical career structure. *Journal of Clinical Nursing, 9,* 347-359.

Manuel, P., & Sorensen, L. (1995). Changing trends in healthcare: Implications for baccalaureate education, practice and employment. *Journal of Nursing Education, 34,* 248-253.

Marcum, E. H., & West, R. D. (2004). Structured orientation for new graduates: A retention strategy. *Journal for Nurses in Staff Development, 20,* 118-124.

Marles, F. (1989). *The Politics of Nursing in Victoria in 1987.* Gealong: Deakin University press.

Martin, C. (2002). The theory of critical thinking of nursing. *Nursing Education Perspectives, 23*(5), 243-247.

Matuscak, R. R. (1983). Criteria, purposes, and methods for evaluating the clinical competence of students in the allied health professions. *Journal of Allied Health, 12,* 85-94.

May, B. A., Edell, V., Butell, S., Doughty, J., & Langford, C. (1999). Critical thinking and clinical competence: A study of their relationship in BSN seniors. *Journal of Nursing Education, 38,* 100-110.

Mayan, M. J. (2001). *An introduction to qualitative methods: A training module for students and professionals*. Edmonton, AB: International Institute for Qualitative Methodology.

Maynard, C. A. (1991). The relationship of critical thinking ability, stage of skill acquisition, years of practice, and organizational context to professional nursing competence. (Doctoral dissertation, University of Minnesota, 1991). *Dissertation Abstracts International, 53*, 2428A.

Maynard, C. A. (1996). Relationship of critical thinking ability to professional nursing competence. *Journal of Nursing Education, 35*(1), 12-18.

McCabe, C. (2004). Nurse-patient communication: An exploration of patients' experiences. *Journal of Clinical Nursing, 13,* 41-49.

McCloskey, J. C. (1981). The effects of nursing education on job effectiveness: An overview of the literature. *Research in Nursing &Health, 4,* 355-373.

McCloskey, J. C. (1983). Nursing education and job effectiveness. *Nursing Research, 32*(1), 53-58.

McCloskey, J. C., & McCain, B. E. (1987). Satisfaction, commitment and professionalism of newly employed nurses. *Image: Journal of Nursing Scholarship,19*(1), 20-24.

McCloskey, J. C., & McCain, B. (1988). Variables related to nurse performance. *Image: Journal of Nursing Scholarship, 20*(4), 203-207.

McCloskey, J. M. (1998). Nurse staffing and patient outcomes. *Nursing Outlook, 46,* 199-200.

McKenna, B. G., Smith, N. B., Poole, S. J., & Coverdale, J. H. (2003). Horizontal violence: Experiences of Registered Nurses in their first year of practice. *Journal of Advanced Nursing, 42,* 90-96.

McMullan, M., Endacott, R., Gray, M. A., Jasper, M., Miller, C. M. L., Scholes, J. et al. (2003). Portfolios and assessment of competence: A review of the literature. *Journal of Advanced Nursing, 41*(3), 283-294.

Meijers, J. M., Janssen, M. A., Cummings, G. G., Wallin, L., Estabrooks, C. A., & Halfens, Y. G. (2006). Assessing the relationships between contextual factors and research utilization in nursing: systematic literature review. *Journal of Advanced Nursing, 55,* 622-635.

Meleis, A. I. (1996). Culturally competent scholarship: Substance and rigor. *ANS Advances in Nursing Science, 19,* 1-16.

Meretoja, R., Eriksson, E., & Leino-Kilpi, H. (2002). Indicators for competent nursing practice. *Journal of Nursing Management, 10*(2), 95-102.

Meretoja, R., Isoaho, H., & Leino-Kilpi, H. (2004). Nurse competence scale: Development and psychometric testing. *Journal of Advanced Nursing, 47,* 124-133.

Meretoja, R., & Leino-Kilpi, H. (2001). Literature review. Instruments for evaluating nurse competence. *Journal of Nursing Administration, 31*(7/8), 346-352.

Meretoja, R., & Leino-Kilpi, H. (2003). Comparison of competence assessments made by nurse managers and practising nurses. *Journal of Nursing Management, 11,* 404-409.

Meretoja, R., Leino-Kilpi, H., & Kaira, A. M. (2004). Comparison of nurse competence in different hospital work environments. *Journal of Nursing Management, 12,* 329-336.

Messick, S. (1984). The psychology of educational measurement. *Journal of Educational Measurement, 21,* 238.

Miles, M. B., & Huberman, A. M. (1994). *An expanded source book: Qualitative data analysis*. (2nd ed.) Thousand Oaks: Sage.

Millar, S. (1980). Entry into practice: A nuts-and-bolts appraisal. *Heart and Lung, 9,* 977-978.

Miller, G. P. (1996). *The unit head nurse in Pakistani hospitals: Current and desired level of practice*. Unpublished doctoral dissertation, University of Wales, Cardiff.

Ministry of Women Development. (1998). *National plan of action* Islamabad, Pakistan: Author.

Moeti, M. R., van Niekerk, S. E., & van Velden, C. E. (2004). Perceptions of the clinical competence of newly registered nurses in the North West province. *Curationis: South African Journal of Nursing,* 72-84.

Monash University (1998). The History and Development of Key Competencies. Retrieved December 20, 2004, from: http://www.education.monash.edu.au/projects/kc/bkgd.htm

Moore, L., & Savage, J. (2002). Participant observation, informed consent and ethical approval. *Nurse Researcher, 9,* 58-69.

Morgan, P., & French, S. E. (1993). *Development of Women in Health Sector in Pakistan* Canada: CIDA.

Morse, J. M. (1991). Strategies to sampling. In J. M. Morse (Ed.), *Qualitative Nursing Research: A contemporary dialogue* (pp. 117-131). Newbury Park, CA: Sage.

Morse, J. M. (1992). Ethnography. In J. M. Morse (Ed.), *Qualitative Health Research* (pp. 141-144). Newbury Park: Sage.

Morse, J. M. (1994a). Dialogue: On being a stranger in the field. In J. M. Morse (Ed.), *Critical Issues in qualitative research methods* (pp. 316-317). Thousand Oaks: Sage.

Morse, J. M. (1994b). Dialogue: On emic and etic. In J. M. Morse (Ed.), *Critical Issues in qualitative research methods* (pp. 158). Thousand Oaks: Sage.

Morse, J. M. (2000). Exploring pragmatic utility: Concept analysis by critically appraising the literature. In B. L. Rodgers & K. A. Knafl (Eds.), *Concept Development in nursing: Foundations, techniques, and applications* (2nd ed., pp. 333-352). Philadelphia, PA: W. B. Saunders.

Morse, J. M., Barrett, M., Mayan, M. J., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. International Journal of Qualitative Methods, 1 (2), Article 2.Retrived July 18, 2004, from: http://www.ualberta.ca/~ijqm/

Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals*. (2nd ed.) Thousand Oaks, CA: Sage.

Morse, J. M., & Richards, L. (2002). *Read me first for a user's guide to qualitative methodology*. Thousand Oaks, CA: Sage.

Muecke, M. A. (1994). On the evaluation of ethnographies. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 187-209). Thousand Oaks, CA: Sage.

Mumtaz, K., & Shaheed, F. (2005). *Women in Pakistan: Two steps forward, one step back?* London: Zen Books.

Newble, D. I. (1992). Assessing clinical competence at the undergraduate level. *Medical Education, 26,* 504-511.

Nichols, E. F., & Chitty, K. K. (2005). Educational patterns of nursing. In K. K. Chitty (Ed.), *Professional nursing: Concepts and challenges* (4th ed., pp. 31-60). St .Louis: Elsevier Saunders.

Norman, G. R. (1985). Defining competence: A methodological review. In V. R. Neufeld & G. R. Norman (Eds.), *Assessing clinical competence* (pp. 15-35). New York: Springer.

Nursing and Midwifery Council, United Kingdom Central Council. (2002). *Professional conduct*. Retrieved November 10, 2004, from http://www.nmc-uk.org/nmc/main/publications/professionalConduct

O'Connor, S. E., Pearce, J., Smith, R. L., Vogeli, D., & Walton, P. (1999). Monitoring the quality of pre-registration education: Development, validation and piloting of competency based performance indicators for newly qualified nurses. *Nurse Education Today, 19,* 334-341.

O'Connor, S. E., Pearce, J., Smith, R. L., Voegeli, D., & Walton, P. (2001). An evaluation of the clinical performance of newly qualified nurses: A competency based assessment. *Nurse Education Today, 21,* 559-568.

Oermann, M. H. (1997). Evaluating critical thinking in clinical practice. *Nurse Educator, 22*(5), 25-28.

Oermann, M. H., & Moffitt-Wolf, A. (1997). New graduates' perceptions of clinical practice. *Journal of Continuing Education in Nursing, 28,* 20-25.

O'Lynn, C. E., & Tranbarger, R. E. (2007). *Men in nursing: History, challenges and opportunities*. New York: Springer.

Ovalle, M. (2000). *Competency-based approach to education: Appropriateness for nursing education*. Unpublished manuscript. Retrieved November 6, 2004, from http://www.see-educoop.net/education_in/pdf/eur_strat_nurs_top1-8-04-oth-enl-t06.pdf

*Oxford English Dictionary*. (2005). Retrieved September 01, 2004, from *http://dictionary.oed.com/cgi/entry/00177537?query*

Pakistan - Linguistic and Ethnic Groups (1994). Source: The Library of Congress Country Studies; CIA World Fact book (1994). Retrieved October 16, 2005, from: http://countrystudies.us/pakistan/31.htm.

Pakistan Nursing Council (1996). *Minutes of Pakistan Nursing Council: Appendix A-AKUSON generic BScN degree programme proposal* Islamabad, Pakistan: Author.

Parker, N. I., & Humphreys, J. (1973). *Survey of graduates of the University of Toronto baccalaureate course in nursing, 1972*. Toronto: Faculty of Nursing, University of Toronto.

Parse, R. R. (2003). A call for dignity in nursing. *Nursing Science Quarterly, 16,* 193-194.

Pearson, A. (2002). The "competent" nurse? *International Journal of Nursing Practice, 8,* 233-234.

Pearson, A., & Peels, S. (2001). A global view of nursing in the new millennium. Part 5: Problems faced by nurses. *International Journal of Nursing Practice, 7,* S21-S25.

Pellatt, G. (2003). Ethnography and reflexivity: Emotions and feelings in fieldwork. *Nurse Researcher, 10,* 28-37.

Piantanida, M., & Garman, N. B. (1999). *The qualitative dissertation: A guide for students and faculty.* Thousand Oaks, CA: Corwin Press.

Polanyi, M. (1976). Tacit knowing. In M. Marx & F. Goodson (Eds.), *Theories in contemporary psychology* (pp. 330-344). New York: Macmillan.

Polit, D. F., & Beck, C. T. (2004). *Nursing Research: Principles and methods.* (7th ed.) Philadelphia: Lippincott.

Polit, D. F., Beck, C. T., & Hungler, B. P. (2001). *Essential of nursing research: Methods, appraisal, and utilization.* (5th ed.) Philadelphia : Lippincott Williams & Wilkins.

Poster, E., Adams, P., Clay, C., Garcia, B. R., Hallman, A., Jackson, B. et al. (2005). The Texas model of differentiated entry-level competencies of graduates of nursing programs. *Nursing Education Perspectives, 26,* 18-23.

Proehl, J. A. (2002). Assessing emergency nursing competence. *Nursing Clinics of North America, 37,* 97-110, vii.

Quinn, F. M. (1995). *The principles and practice of nurse education.* (3rd ed.) London, UK: Chapman and Hall.

Rabetoy, C. P. (2002). *Response by Christy Price to Rabetoy to*: *The 1965 Entry Into Practice Proposal - Is It Relevant Today?* Retrieved July 12, 2005, from http://www.nursingworld.org/ojin/letters/t18e7.htm

Ramritu, P. L., & Barnard, A. (2001). New nurse graduates' understanding of competence. *International Nursing Review, 48,* 47-57.

Redfern, S., Norman, I., Calman, L., Watson, R., & Murrells, T. (2002). Assessing competence to practice in nursing: A review of the literature. *Research Papers in Education, 17,* 51-77.

Robb, Y., Fleming, V., & Dietert, C. (2002). Measurement of clinical performance of nurses: A literature review. *Nurse Education Today, 22,* 293-300.

Roberts, B. J., Jones, C., & Lynn, M. (2004). Job satisfaction of new baccalaureate nurses. *Journal of Nursing Administration, 34,* 428-435.

Rogers, A. E., Hwang, W. T., Scott, L. D., Aiken, L. H., & Dinges, D. F. (2004). The working hours of hospital staff nurses and patient safety. *Health Affairs, 23,* 202-212.

Roper, J. M., & Shapira, J. (2000). *Ethnography in nursing research*. Thousand Oaks, CA: Sage.

Roseman, C., & Booker, J. M. (1995). Workload and environmental factors in hospital medication errors. *Nursing Research, 44,* 226-230.

Ross, H., & Clifford, K. (2002). Research as a catalyst for change: The transition from student to Registered Nurse. *Journal of Clinical Nursing, 11,* 545-553.

Ross, M., Carroll, G., Knight, J., Chamberlain, M., Fothergill-Bourbonnais, F., & Linton, J. (1988). Using the OSCE to measure clinical skills performance in nursing... objective structured clinical examination. *Journal of Advanced Nursing, 13,* 45-56.

Ross-Kerr, J. (1999). Entry to practice: Striving for the baccalaureate standard. In J. Ross-Kerr & J. MacPhail (Eds.), *Canadian nursing issues and perspectives* (3rd ed., pp. 321-333). Toronto, ON: Mosby.

Rossi, P. H., Lipsey, M. W., & Freeman, H. E. (2004). *Evaluation: A systematic approach*. Thousand Oaks: Sage.

Ryan, D., & Brewer, K. (1997). Mentorship and professional role development in undergraduate nursing education. *Nurse Educator, 22,* 20-24.

Ryan, M. E., & Hodson, K. E. (1992). Employer evaluations of nurse graduates: A critical program assessment element. *Journal of Nursing Education, 31,* 198-202.

Sabiston, J. A., & Laschinger, H. K. (1995). Staff nurse work empowerment and perceived autonomy. Testing Kanter's theory of structural power in organizations. *Journal of Nursing Administration, 25,* 42-50.

Saleem, N., Shah, S., & Nagi, S. (1992). *History of nursing in Pakistan*. Islamabad: Pakistan Nursing Council.

Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science, 8,* 27-37.

Sasichay-Akkadechanunt, T., Scalzi, C. C., & Jawad, A. F. (2003). The relationship between nurse staffing and patient outcomes. *Journal of Nursing Administration, 33*(9), 478-485.

Saylor, C. R. (1990). Reflection and professional education: Art, science, and competency. *Nurse Educator, 15,* 8-11.

Schutzenhofer, K. K., & Musser, D. B. (1994). Nurse characteristics and professional autonomy. *Image: Journal of Nursing Scholarship, 26,* 201-205.

Schwirian, P. M. (1978). Evaluating the performance of nurses: A multidimensional approach. *Nursing Research, 27,* 347-351.

Sellick, K. J., Russell, S., & Beckmann, J. L. (1983). Primary nursing: An evaluation of its effects on patient perception of care and staff satisfaction. *International Journal of Nursing Studies, 20,* 265-273.

Shafqat, S., & Zaidi, A. K. (2007). Pakistani physicians and the repatriation equation. *The New England Journal of Medicine, 356,* 442-443.

Shattell, M. (2004). Nurse-patient interaction: A review of the literature. *Journal of Clinical Nursing, 13,* 714-722.

Sherman, R. O. (2006). Leading a multigenerational nursing workforce: Issues, challenges and strategies. *The Online Journal of Issues in Nursing. 11*(2). Retrieved April 24, 2007, from: http://www.nursingworld.org/ojin/topic18/tpc18ntr.htm

Short, E. C. (1984). Competence reexamined. *Educational Theory, 34,* 201-207.

Shortell, S. M., Zimmerman, J. E., Rousseau, D. M., Gillies, R. R., Wagner, D. P., Draper, E. A. et al. (1994). The performance of intensive care units: Does good management make a difference? *Medical Care, 32,* 508-525.

Siebens, K., Casterle, B. D., Abraham, I., Dierckx, K., Braes, T., Darras, E. et al. (2006). The professional self-image of nurses in Belgian hospitals: A cross-sectional questionnaire survey. *International Journal of Nursing Studies, 43,* 71-82.

Smith, J. E. (2002). Analysis of differences in entry-level RN practice by educational preparation. *Journal of Nursing Education, 41,* 491-494.

Smith, T. C. (1998). From the editor... providers need to be enabled to truly manage care, rather than just manage costs. *Journal of Nursing Care Quality, 12,* viii.

Sochalski, J. (2004). Is more better?: The relationship between nurse staffing and the quality of nursing care in hospitals. *Medical Care, 42,* (Suppl. 2), 1167-1173.

Sovie, M. D., & Jawad, A. F. (2001). Hospital restructuring and its impact on outcomes: Nursing staff regulations are premature. *Journal of Nursing Administration, 31,* 588-600.

Speedling, E. J., Ahmadi, K., & Kuhn-Weissman, G. (1981). Encountering reality: Reactions of newly hired R.N.'s to the world of the medical center. *International Journal of Nursing Studies, 18,* 217-225.

Spradley, J. P. (1979). *The ethnographic interview*. New York: Holt, Rinehart & Winston.

Spradley, J. P. (1980). *Participants observation*. New York: Holt, Rinehart & Winston.

Stelzer, J. (1992). Morale issues in crisis intervention units. *Paper given at 2nd International Conference on Children Death*. In University of Edinburgh, Edinburgh.

Stevens, S. S. (1946). On the theory of scales of measurement. *Science, 103,* 677-680.

Stommel, M., & Wills, C. E. (2004). Data collection techniques. In *Clinical research: Concepts and principles for advanced practice nurses* (pp. 244-263). Philadelphia, PA: Lippincott Williams & Wilkins.

Street, A. F. (1992). *Inside nursing: A critical ethnography of clinical nursing practice*. Al-Bany: State University of New York.

Streubert-Speziale, H. J., & Carpenter, D. R. (2003). *Qualitative research in nursing: Advancing the humanistic imperative*. (3rd ed.) Philadelphia, PA: Lippincott.

Stull, E. V. (1986). Staff nurse performance: Effects of goal setting and performance feedback. *Journal of Nursing Administration, 16,* 26-30.

Suh, E. E. (2004). The model of cultural competence through an evolutionary concept analysis. *Journal of Transcultural Nursing, 15,* 93-102.

Swanson, J. M., & Chapman, L. (1994). Inside the black box: Theoretical and methodological issues in conducting evaluation research using qualitative approach. In J. M. Morse (Ed.), *Evaluation criteria and critique of qualitative research studies* (pp. 66-93). Thousand Oaks, CA: Sage.

Sweeney, M. A., Regan, P., O'Malley, M., & Hedstrom, B. (1980). Essential skills for baccalaureate graduates: Perspective of education and practice. *The Journal of Nursing Administration,10,* 37-44.

Taris, T. W. (2006). Is there a relationship between burnout and objective performance? A critical review of 16 studies. *Work & Stress, 20,* 316-334.

Taylor, C. (1995). Rethinking nursing's basic competencies. *Journal of Nursing Care Quality, 9,* 1-13.

The Aga Khan University School of Nursing (2005). *Degree Programme: Student Handbook 2004-2005*. Karachi, Pakistan: Author.

Titler, M. G., Kleiber, C., Steelman, V., Goode, C., Rakel, B., Barry-Walker, J. et al. (1994). Infusing research into practice to promote quality care. *Nursing Research, 43,* 307-313.

Tzeng, H. M. (2004). Nurses' self-assessment of their nursing competencies, job demands and job performance in the Taiwan hospital system. *International Journal of Nursing Studies, 41,* 487-496.

Tzeng, H. M., & Ketefian, S. (2003). Demand for nursing competencies: An exploratory study in Taiwan's hospital system. *Journal of Clinical Nursing, 12,* 509-518.

ul Haq, M. (1997). *Human Development in South Asia*. New York.: Oxford University Press.

UNICEF (2005). At a glance: Pakistan Statistics. Retrieved August 19, 2005, from: www.unicef.org

University of Missouri Health Care (2006). Registered Nurse Salary. Retrieved May 09, 2007, from: http://jobs.muhealth.org/Recruit/RN_salaries.pdf

Upton, D. J. (1999). How can we achieve evidence-based practice if we have a theory-practice gap in nursing today? *Journal of Advanced Nursing, 29,* 549-555.

Upvall, M. J., Kanji, Z., Jaffer, S., Khowaja, K., Barolia, R., & Amarsi, Y. (2002a). Defining the cultural milieu for implementing faculty practice in Pakistan. *International Journal of Nursing Practice, 8,* 315-323.

Upvall, M. J., Karmaliani, R., Pirani, F., Gul, R., & Khalid, F. (2004). Developing nursing leaders through graduate education in Pakistan. *International Journal of Nursing Education Scholarship, 1*. Retrieved May18, 2005, from: http://www.bepress.com/ijnes/vol1/iss1/art27.

Upvall, M. J., Rehmatullah, S., Hashwani, S., Khan, S., Husain, P., & Jan, R. (1999). The implementation of a Bachelor of Science in nursing education in Pakistan. *Nursing and Health Sciences, 1,* 221-228.

Upvall, M. J., Sochael, S., & Gonsalves, A. (2002b). Behind the mud walls: The role and practice of lady health visitors in Pakistan. *Health Care for Women International, 23,* 432-441.

Utley-Smith, Q. (2004). 5 competencies needed by new baccalaureate graduates. *Nursing Education Perspectives, 25*(4), 166-170.

Vahey, D. C., Aiken, L. H., Sloane, D. M., Clarke, S. P., & Vargas, D. (2004). Nurse burnout and patient satisfaction. *Medical Care, 42,* (Suppl. 2), 57-66.

Vellani, C. W. (1994). *Foreword. The Aga Khan University prospectus.* Karachi, Pakistan: Aga Khan University.

Waddell, D. L. (2001). Measurement issues in promoting continued competence. *Journal of Continuing Education in Nursing, 32,* 102-106.

Waltz, C. F., Strickland, O. L., & Lenz, E. R. (1991). *Measurement in nursing research.* (2nd ed.) Philadelphia: F. A. Davis.

Warner, J. R. (2002). Cultural competence immersion experiences: Public health among the Navajo. *Nurse Educator, 27,* 187-190.

Waters, V. H., Vivier, M. L., Chater, S. S., Urrea, J. H., & Wilson, H. S. (1972). Technical and professional nursing: An exploratory study. *Nursing Research, 21,* 124-131.

Watson, R. (2002). Clinical competence: Starship enterprise or straitjacket? *Nurse Education Today, 22,* 476-480.

Watson, R., Stimpson, A., Topping, A., & Porock, D. (2002). Clinical competence assessment in nursing: A systematic review of the literature. *Journal of Advanced Nursing, 39,* 421-431.

Weir, G. M. (1932). *Survey of Nursing Education in Canada.* Toronto: University of Toronto Press.

Wharrad, H., & Robinson, J. (1999). The global distribution of physicians and nurses. *Journal of Advanced Nursing, 30,* 109-120.

While, A. E. (1994). Competence versus performance: Which is more important? *Journal of Advanced Nursing, 20,* 525-531.

Whitehead, J. (2001). Newly qualified staff nurses' perceptions of the role transition. *British Journal of Nursing, 10,* 330-339.

Wieck, K. L., Prydun, M., & Walsh, T. (2002). What the emerging workforce wants in its leaders. *Journal of Nursing Scholarship, 34,* 283-288.

Wood, I. (1998). The effects of continuing professional education on the clinical practice of nurses: A review of the literature. *International Journal of Nursing Studies, 35,* 125-131.

Woodruffe, C. (1993). What is meant by a competency? *Leadership and Organization Development Journal, 14,* 29-36.

World Bank (1999/2000). *Entering the 21st century: World Development Report 1999/2000.* New York, NY: Oxford University Press.

World Health Organization (1956). *Report of a study group basic nursing curriculum.* Geneva: Author.

World Health Organization (1997). *Strengthening nursing and midwifery. A Global Study* WHO Geneva.

World Health Organization (2004). *WHO-Regional Office for the Eastern Mediterranean. Country profiles-Pakistan*. Retrieved August 19, 2005, from: http://www.emro.who.int

Worth-Butler, M., Murphy, R. J., & Fraser, D. M. (1994). Towards an integrated model of competence in midwifery. *Midwifery, 10,* 225-231.

Young, S. W., & Sowell, R. L. (1997). A case management curricular model. The challenge for nursing education. *Nurse Educator, 22,* 13-18.

Zhang, Z., Luk, W., Arthur, D., & Wong, T. (2001). Nursing competencies: Personal characteristics contributing to effective nursing performance. *Journal of Advanced Nursing, 33,* 467-474.

# APPENDIX A:

## LETTERS OF SUPPORT:

## AGA KHAN UNIVERSITY SCHOOL OF NURSING AND HOSPITAL

# APPENDIX B:

# ETHICS APPROVAL:

# UNIVERSITY OF ALBERTA AND AGA KHAN UNIVERSITY

# APPENDIX C:

# LETTER OF INVITATION

## Letter of Invitation

Dear Potential Participants,

My name is Raisa Gul, and I am an employee of Aga Khan University. Currently, I am on study leave to complete my doctoral studies at the University of Alberta, Canada.

For my doctoral thesis I am interested in exploring and understanding the experiences and perceptions of four-year BScN graduates and their supervisors—that is, head nurses—at Aga Khan University Hospital. Therefore, I am looking for graduates of the four-year BScN program and their supervisors (such as head nurses) who may wish to volunteer to share their views with me.

If you wish to receive more information about this study or are interested in participating, please call me at 457-1160- or 494-6871.

Thank you.

Raisa Gul
PhD Candidate
Faculty of Nursing, U. of A.

# APPENDIX D:

# POSTER FOR INVITATION

# *Title of the Study*: Competence of Graduates of the Four-Year BScN Program at Aga Khan University: Experiences and Perceptions

Are you a graduate of four-year BScN program?

Do you have some work experience at Aga Khan University?

OR

Are you working in a supervisory Position, such as Head Nurse or Clinical Coordinator?

Do you work with nurses that are graduated from four BScN program?

*If your answer is yes to either set of questions, you are a potential participant for the above study.*

*If you wish to participate in this study, Kindly contact me at 4930051-Ext. 5470/5428 or 457-1160 between 8AM to 8 PM.*

*Thank you.*

*Raisa Gul*
*PhD Candidate, University of Alberta*

# APPENDIX E:

# INFORMATION LETTERS: INTERVIEWS AND OBSERVATIONS

## Competence of Graduates of the Four-Year BScN Program at Aga Khan University: Experiences and Perceptions

### Information Letter for Interviews

**Investigator:**
Raisa Gul, PhD Candidate, University of Alberta.
Email address: rgul@ualberta.ca
Phone # in Pakistan: 4930051 Ext. 4500

**Co-Supervisors:**

| | |
|---|---|
| *Dr. Joanne Olson* | *Dr. Pauline Paul* |
| *Professor &* | *Associate Professor & Associate Dean* |
| *Year 1 Coordinator* | *Academic Planning & Programs* |
| *Faculty of Nursing, University of Alberta* | *Faculty of Nursing, University of Alberta* |
| *Joanne.olson@ualberta.ca* | *pauline.paul@ualberta.ca* |
| *Telephone number 1 (780) 492-6250* | *Telephone number: 1 (780) 492-7479* |

**Purpose of the Study**

I am an employee of Aga Khan University and currently studying at the University of Alberta in Canada. Completion of this study is part of the requirement for my PhD program.

The purpose of this study is to explore and understand experiences and perceptions of the BScN graduates and their supervisors about the graduates' abilities to carryout their roles at Aga Khan University (AKU). An additional purpose of the study is to explore the differences in perception of the expected and actual performance of BScN graduates at AKU.

For data collection, I will conduct interviews with BScN graduates and head nurses at AKU. I will also make some observations on the selected nursing units to make sense of the nurses' work environment and expectations. In addition, I will also analyze some institutional documents which are relevant to nurses' work, such as job description or career ladder.

Findings of this study may help to identify future directions in nursing education and practice, both at institutional and national level.

**Process for Interviews**

If you wish to share your views with me through an interview, I will first ask you some simple work related questions, such as your title, work unit, and length of nursing experience. This information will help me to select nurses from different units and back grounds. Once you are selected for an interview, I will interview you for approximately 60- 90 minutes. The interviews will be audio taped. It will be held at a time and place that is convenient for you. The interview will be conducted in your off hours from work. I will give you a small token of appreciation to contribute towards your transportation cost. A few days after the interview I will ask you to review the interview transcript to ensure that you agree about the content of the transcript. If I have an additional question or need further clarification, we may do that on the phone or in a face to face conversation.

**Risks/Benefits**

I do not know of any risks to you for being in this study. However, at any time if you need to take a break you can tell me and we will stop the interview. If for any reason, you become upset during the interview, it will be possible stop the interview. If required, I will be able to guide you to see a counselor.

There is no direct benefit of this research to you. However, it will give you an opportunity to share your unique perception and contribute to a project that may bring positive outcome to nursing education and practice in Pakistan, but particularly at AKU with positive patient care implications.

**Confidentiality and Privacy**

Identity of other participants will not be revealed to you whether you are head nurse or a staff nurse. [illegible] will not tell the person whether you choose to participate or not. To maintain anonymity, your real name in the transcript will be replaced with a pseudonym. The person who transcribes the interviews will also follow the principles of confidentiality. The information you provide will be kept for at least five years.

Copies of the information letter and consent form will be kept in a locked filling cabinet. Tapes and original transcripts will be locked in a separate locked filing cabinet in an office at AKU-SON. A copy of the transcript will be stored with the co-supervisors at the University of Alberta. Only the researcher will have access to the tapes and consent forms, whereas copy of the transcript will be accessed by the supervisors besides the researcher.

Interviews data will be confidential and NOT shared with your colleagues, supervisors, teachers or AKU administration in a raw form. However, aggregated findings of this project will be widely disseminated without revealing your identity. Some of the things that you state in the interview may be directly quoted in the text of my thesis or subsequent publications, but without any associating identity (name or specific designation) with that text. All efforts will be made not to reveal your identity. A copy of my completed thesis will be kept at health sciences library-AKU.

There is also a possibility that the data from this study may be useful for future studies. However, for a secondary analysis of the data approval must be sought from the Ethical Review Committee at Aga Khan University.

**Consent and Freedom to Participate**

Participation in this study is entirely voluntary. You may consent to participate in this study; you may withdraw at any time. There is no penalty for withdrawing. Participating or not participating in the study will not affect your employment in any way.

**Contacts for Questions or Concerns**

If you have any questions about this research, you may contact me or one of my thesis supervisors. If you have any concerns about this study you may contact Dr. Yasmin Amarsi, Dean of the Aga Khan University School of Nursing, at 49346876.

______________________________ ______________________________

**Researcher's Initials** **Date**

**Competence of Graduates of the Four-Year BScN Program at Aga Khan University: Experiences and Perceptions**

## Information letter for Observations

**Investigator:**
Raisa Gul, PhD Candidate, University of Alberta.
Email address: rgul@ualberta.ca
Phone # in Pakistan: 4930051 Ext. 4500

**Co-Supervisors:**

| | |
|---|---|
| *Dr. Joanne Olson* | *Dr. Pauline Paul* |
| *Professor &* | *Associate Professor &* |
| *Year 1 Coordinator* | *Associate Dean Academic Planning & Programs* |
| *Faculty of Nursing, University of Alberta* | *Faculty of Nursing, University of Alberta* |
| *Joanne.olson@ualberta.ca* | *pauline.paul@ualberta.ca* |
| *Telephone number 1 (780) 492-6250* | *Telephone number: 1 (780) 492-7479* |

### Purpose of the Study

I am an employee of Aga Khan University and currently studying at the University of Alberta in Canada. Completion of this study is part of the requirement for my PhD program.

The purpose of this study is to explore and understand experiences and perceptions of the BScN graduates and their supervisors about the graduates' abilities to carryout their roles at Aga Khan University (AKU). An additional purpose of the study is to explore the differences in perception of the expected and actual performance of BScN graduates at AKU.

For data collection, I will conduct interviews with BScN graduates and head nurses at AKU. I will also make some observations and analyze some institutional documents that are relevant to nurses' work, such as job description or career ladder.

Findings of this study may help to identify future directions in nursing education and practice, both at institutional and national level.

**Process for Observations**

I will make observations on 2-3 units that greatly differ in their work environment. Overall, I may spend up to 48 hours in one unit. The purpose of observation is to make general sense of the nurses' work environment and expectations but not to follow an individual nurse for his/her performance. I may observe or participate in various activities of the staff other than patient-care delivery; for example, staff interaction at a nursing station and during shift report, ward meetings or in-service sessions, or joining you over the tea and meal breaks. I may take some field notes while or after an observation. If I see an action or interaction that might be interpreted in different ways, I may ask the nurse(s) involved for their perspective. I will not intervene in your interactions in my role as a researcher, other than a life threatening situation.

**Risks/Benefits**

I do not know of any risks to you for being in this study, but you may have a sense of awkwardness or anxiety for being observed on the unit. Likewise, you may feel embarrassed or anxious when sharing your thoughts during a conversation. However, if you don't want to talk to me, or allow me to observe you on the unit, I will not mind it and it will have no future consequences because your participation in this research is voluntary.

There is no direct benefit of this research to you. However, it will give you an opportunity to contribute to a project that may bring positive outcome to nursing education and practice in Pakistan, but particularly at AKU with positive patient care implications.

**Confidentiality and Privacy**

To maintain anonymity, field notes will be coded. Your real name and unit will be replaced with a pseudonym. Only the researcher and her supervisors will have access to the field notes. The information gathered during observations will be kept for at least five years. A duplicate copy of this information will also be kept with my supervisors in Canada. Copies of the information letter and consent form will be kept in a locked filling cabinet.

I will make an effort not to observe those who do not wish to be observed, although inadvertent observations may occur, but I will ask no questions of or seek clarifications from those individuals.

Field notes will be confidential and NOT shared with your colleagues, supervisors, teachers or AKU administration in a raw form. However, aggregated findings of this project will be widely disseminated without revealing your identity. Some of the things that I observe may be indicated in the text of my thesis or subsequent publications, but without any associating identity (name or unit) with that text. All efforts will be made not to reveal your identity. A copy of my completed thesis will be kept at health sciences library-AKU.

There is also a possibility that the data from this study may be useful for future studies. However, for a secondary analysis of the data approval must be sought from the Ethical Review Committee at Aga Khan University.

## Consent and Freedom to Participate

Participation in this study is entirely voluntary. I need an individual consent, whether in writing or verbal, from each nurse of this unit for observations. You may consent to participate in this study; you may withdraw at any time. There is no penalty for withdrawing. Participating or not participating in the study will not affect your employment in any way.

## Contacts for Questions or Concerns

If you have any questions about this research, you may contact me or one of my thesis supervisors. If you have any concerns about this study you may contact Dr. Yasmin Amarsi, Dean of the Aga Khan University School of Nursing, at 49346876.

| | |
|---|---|
| ______________________________ | ______________________________ |
| **Researcher's Initials** | **Date** |

# APPENDIX F:

# INTERVIEW GUIDES: GRADUATES AND SUPERVISORS

## Interview Guide for BScN Graduates

| No. | Questions | Purpose of the question (s) |
|---|---|---|
| 1 | In your view, what characteristics/ attributes are needed to be viewed as competent nurse in your unit? | Expectations of supervisors and customers in the context, Perception of being competent? |
| 2 | How would you describe a successful nurse? | Perception of role effectiveness |
| 3 | What is it like to be a graduate of the BScN program in the work environment?<br>How is your relationship with other staff on the unit? | (grand tour question) |
| 4 | How was (or is) your transition from a new graduate to confident professional?<br>What did /do you find helpful? and What did/do you find not helpful? | Determine experience of transition from novice and experienced graduates and hence, the nature of their context (facilitative and impeding factors). |
| 5 | How do you find your role as a staff nurse? | Role perception |
| 6 | Is there any aspect of your role that you wish to see it change? | |
| 7 | What drives or motivates you to work? | |
| 8 | To what extent has your professional education prepared you for your work at present?<br>What you are able to apply or not able to apply that you have learned in your professional education?<br>Or<br>Are your abilities being used to your full potential in your setting? | To identify the gap between education and practice. (further probes will used in this question as what they are able to apply or not and why |
| 9 | What are your strengths as a degree nurse? | Strengths and weakness of the graduates |
| 10 | What are the challenges in using those strengths?<br>How confident are you in the following areas (Please provide me an example):<br>Problem solving<br>Critical thinking<br>Interpersonal skills<br>Safe and ethical care<br>Self directedness | Determine their self-perception of competence in specific areas |

| | | |
|---|---|---|
| 11<br><br><br><br><br>12 | In what ways are you able to apply or use your knowledge about research?<br><br>Have you been involved in any research activities since your graduation? If yes, tell me more about it?<br><br>What kind of teaching activities are you involved with?<br>Patients/families<br>Colleagues<br>Students | Determining opportunities<br>Professional development<br>Which is part of competence |
| 13 | What were your feelings about nursing:<br>• before joining the program<br>• at the completion of your program<br>• Now | To inquire if the expectations of graduates from nursing changed during education or work-what they thought of nursing and what is like now. |
| 14 | Do you think your parents would have supported your decision to join the diploma program in nursing if the BScN program had not been available? | Parents' perception of Nursing and the BScN program |
| 15<br><br><br><br>16 | If you had to advise a young person who wants to join nursing, would you suggest that person to take the BScN program? Why? Why not?<br><br>Is a diploma program adequate for general nursing care? And why? | Elicit perception about BScN program. |
| 17<br><br><br>18<br><br><br>19 | Where would you like to see yourself 5 years from now?<br><br>If you have an opportunity to change your profession, what would you choose? Why?<br><br>If you want to change your profession, what would make you want to stay? | Future aspirations<br><br>Assess attitude toward nursing and the desire to change? And what is missing in nursing. |
| 20 | What suggestion do you have about the four -year BScN program in future?<br>OR<br>What changes would you wish to recommend in regards to curriculum for the four -year BScN program? | Program improvement<br>Curriculum gaps |

## Interview Guide for Head Nurses

| No. | Questions | Purpose of the question (s) |
|---|---|---|
| 1<br>2 | How would you describe a successful nurse?<br>What abilities do you believe are necessary for effective nursing practice or performance? | Perception of role effectiveness<br>Competencies underlying competent performance |
| *3 | What are your views about BScN graduates?<br>What do you see as their strength?<br>What do you see as their challenges? | Perception of competence |
| 4<br>5 | What do you expect from a graduate (BScN) nurse?<br>How do you communicate these expectations?<br>To what extent BScN nurses are prepared for what is expected of them in the nursing workforce? | What is expected of BScN<br>Adequacy of the program |
| 6 | How do BScN graduates contribute to the delivery of patient care? | Perception of competence |
| *7 | How do you find BScN in terms of their leadership skills? | Perception of competence in specific area |
| *8 | What are your views about skills of BScN Nurses in regards to:<br>Problem solving (judgment and decision-making)<br>Ability to organize and prioritize<br>Critical thinking; Interpersonal skills<br>Safe and ethical care ; Self directedness<br>Teaching; Research | Perception of competence |
| 9<br>10 | If you had to advise a young person who wants to join nursing, would you suggest that person to take the BScN program? Why? Why not?<br>Is a diploma program adequate for general nursing care? And why? | Perception of the program |
| 11 | Are the BScN graduates being fully utilized? | Utilization of graduates |
| 12 | What suggestion do you have about the four -year BScN program?<br>OR<br>What changes would you wish to recommend in regards to curriculum for the four -year BScN program? | Curriculum gaps |

* These questions were combined in the analysis.

# APPENDIX G:

# CONSENT FORMS: INTERVIEWS AND OBSERVATIONS

## Consent Form for Interviews

**Title of Project: Competence of Graduates of the Four-Year BScN Program at Aga Khan University: Experiences and Perceptions**

### Part 1: Researcher(s) Information

| | |
|---|---|
| **Name of Principal Investigator**: | Raisa Gul |
| Affiliation: | PhD Candidate, University of Alberta |
| Contact Information: | e-mail < rgul@ualberta.ca > |
| Phone # in Pakistan: | 011-(92-21) 493-0051, Ext. 4500 |
| Contact # in Edmonton: | 780- 461-2402 |

**Name, Affiliation & Contact Information Co-Investigator/Supervisor:**

| | |
|---|---|
| Dr. Joanne Olson<br>Professor &<br>Year 1 Coordinator<br>Faculty of Nursing, University of Alberta<br>Joanne.olson@ualbertaca<br>Telephone number: (1-780) 492-6250 | Dr. Pauline Paul<br>Associate Professor & Associate Dean<br>Academic Planning & Programs<br>Faculty of Nursing, University of Alberta<br>pauline.paul@ualberta.ca<br>Telephone number: (1-780) 492-7479 |

### Part 2: Consent of Subject

| | **Yes** | **No** |
|---|---|---|
| Do you understand that you have been asked to be in a research study? | | |
| Have you read and received a copy of the attached information sheet? | | |
| Do you understand the benefits and risks involved in taking part in this research study? | | |
| Have you had an opportunity to ask questions and discuss the study? | | |
| Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect your employment at Aga Khan University. | | |
| Has the issue of confidentiality been explained to you? Do you understand who will have access to the research data? | | |

### Part 3: Signatures

This study was explained to me by: ______________________________

Date: ______________________________

*I agree to take part in this study.*

Signature of Research Participant: ______________________________

Printed Name: ______________________________

Witness (if available): ______________________________

Printed Name: ______________________________

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Researcher: ______________________________

Printed Name: ______________________________

* A copy of this consent form along with the study information letter will be given to the participants.

# Consent Form for Observations

**Title of Project: Competence of Graduates of the Four-Year BScN Program at Aga Khan University: Experiences and Perceptions**

## Part 1: Researcher(s) Information

**Name of Principal Investigator**: Raisa Gul
Affiliation: PhD Candidate, University of Alberta
Contact Information: email < rgul@ualberta.ca >
Phone # in Pakistan: 011-(92-21) 493-0051, Ext. 4500
Contact # in Edmonton: 780- 461-2402

**Name, Affiliation & Contact Information Co-Investigator/Supervisor:**

| | |
|---|---|
| Dr. Joanne Olson<br>Professor &<br>Year 1 Coordinator<br>Faculty of Nursing, University of Alberta<br>Joanne.olson@ualbertaca<br>Telephone number: (1-780) 492- 6250 | Dr. Pauline Paul<br>Associate Professor & Associate Dean<br>Academic Planning & Programs<br>Faculty of Nursing, University of Alberta<br>pauline.paul@ualberta.ca<br>Telephone number: (1-780) 492-7479 |

## Part 2: Consent of Subject

| | Yes | No |
|---|---|---|
| Do you understand that you have been asked to be in a research study? | | |
| Have you read and received a copy of the attached information sheet? | | |
| Do you understand the benefits and risks involved in taking part in this research study? | | |
| Have you had an opportunity to ask questions and discuss the study? | | |
| Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect your employment at Aga Khan University. | | |
| Has the issue of confidentiality been explained to you? Do you understand who will have access to the research data? | | |
| Do you give me permission to observe your interactions with other staff on the unit? | | |
| Do you give me permission to ask you a question or questions, if I need to clarify what I observe on the unit? | | |

| **Part 3: Signatures** |
|---|
| This study was explained to me by:<br>________________________________________<br>Date: ____________________________________ |
| *I agree to take part in this study.*<br>Signature of Research Participant:<br>________________________________________<br>Printed Name:<br>________________________________________ |
| Witness (if available):<br>________________________________________<br>Printed Name:<br>________________________________________ |
| I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.<br>Researcher: __________________________________<br>Printed Name:<br>________________________________________ |
| * A copy of this consent form along with the study information letter will be given to the participants. |

# APPENDIX H:

# LIST OF REVIEWED DOCUMENTS

## List of Reviewed Documents

| No. | Document | Source |
|---|---|---|
| 1 | Biographic data, BScN graduates (2001-2005) | Student Affairs, AKU-SON. |
| 2 | Assignment List of BScN graduates | Nursing Services, AKUH |
| 3 | Lalani, N.S. (2005), Unpublished master's thesis | AKU-SON |
| 4 | Manasia, R (2004), Report on comparison of care performances-Diploma and BScN nurses | Manasia, R, AKUH |
| 5 | Job description of Registered Nurse | AKU Website |
| 6 | Career Ladder | AKUH |
| 7 | Overtime policy-AKU | AKU Website (Intranet) |
| 8 | Patient documentation forms | North and South Units |
| 9 | Competency Based Orientation (CBO) checklists | North and South Units |
| 10 | Course grid NU 443: Senior Elective | Course Instructor, AKU-SON |
| 11 | List of preceptors for senior electives 2006 | Course Instructor |
| 12 | Students' presentation of North & South Unit | Course Instructor |
| 13 | Turnover record of nurses in Critical Care Area, 2005 | Unit Manager, AKUH |
| 14 | Philosophy of Nursing Services, AKUH | AKU Website (Intranet) |

# APPENDIX I:

# CHARACTERISTICS OF BScN GRADUATES

## Characteristics of BScN Graduates

Table 1

*The Graduates' Province of Origin*

| Province and city of origin | Gender |  | Total | % |
|---|---|---|---|---|
|  | Male | Female |  |  |
| Sindh -Karachi | 7 | 87 | 94 | 71.2 |
| Sindh -Hyderabad | 2 | 9 | 11 | 8.3 |
| NWFP (various) | 19 | 1 | 20 | 15.2 |
| Punjab (various) | 4 | 3 | 7 | 5.3 |
| Total | 32 | 100 | 132 | 100.0 |

Table 2

*The Graduates Duration of Services by Gender at AKUH*

| Duration of Services | Female | Male | Total of all graduates | % |
|---|---|---|---|---|
| Did not join AKUH after graduation | 6 | 5 | 11 | 8 |
| Left within a year | 18 | 15 | 33 | 25 |
| Worked for 1.5-2.5 years | 23 | 4 | 27 | 20 |
| Working with < 1 year experience | 23 | 5 | 28 | 21 |
| Working with > 1 year experience | 11 | 1 | 12 | 9 |
| Working with > 2 years experience | 19 | 2 | 21 | 16 |
| Total | 100 | 32 | 132 | 100 |

Table 3

*Graduates' Employment Status at AKUH by Year of Graduation and Gender*

| Status of graduates | 2001 | 2002 | 2003 | 2004 | 2005 | Total |
|---|---|---|---|---|---|---|
| Number of students graduates | 16 | 26 | 27 | 30 | 33 | 132 |
| Graduates currently employed | 03 | 12 | 06 | 12 | 28 | 61 (46%) |
| Ratio of male to female graduated | 4:12 | 1:25 | 7: 20 | 11:19 | 9: 24 | 32:100<br>24%:76% |
| Ratio of male to female working | 0: 3 | 1:11 | 1:5 | 1:11 | 5:23 | 8: 53<br>6%:40% |

Table 4

*The Graduates' Distribution by Gender and Location of Work*

| Number of graduates per annum | | Current location of work | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | AKUH | AKU-SON/ CHS/ | AKHSP | Non AKU Organization | Migrated Abroad | Not Working | Total |
| 2001 | Female: 12 | 03 | 02 | 00 | 01 | 04 | 02 | 16 |
| | Male: 04 | 00 | 01 | 00 | 01 | 02 | 00 | |
| 2002 | Female: 25 | 11 | 02 | 01 | 02 | 06 | 03 | 26 |
| | Male: 01 | 01 | 00 | 00 | 00 | 00 | 00 | |
| 2003 | Female: 20 | 05 | 02 | 00 | 00 | 10 | 03 | 27 |
| | Male: 07 | 01 | 00 | 00 | 04 | 02 | 00 | |
| 2004 | Female: 19 | 11 | 01 | 01 | 00 | 02 | 04 | 30 |
| | Male: 11 | 01 | 01 | 00 | 06 | 03 | 00 | |
| 2005 | Female: 24 | 23 | 00 | 00 | 00 | 01 | 00 | 33 |
| | Male: 09 | 05 | 00 | 00 | 03 | 01 | 00 | |
| Total # | | 61 | 09 | 02 | 17 | 31 | 12 | 132 |
| Total % | | 46% | 8% | | 13% | 24% | 9% | 100% |

Table 5

*The Graduates' Current Roles in Nursing*

| Place of work | Staff nurses | Critical care nurses | Clinical nurse teachers | Assistant instructors | Instructors/ Sr. instructors | Management | Not working | Total |
|---|---|---|---|---|---|---|---|---|
| AKUH | 39 | 13 | 05 | 02 | 00 | 02 |  | 61 (46%) |
| AKU-SON/ AKU-CHS |  | 01 |  |  | 08 | 02 |  | 11 (8 %) |
| Non-AKU organization | 02 |  |  | 03 | 08 | 04 |  | 17 (13%) |
| Migrated abroad | 23[3] | 01 |  |  |  |  | 07 | 31 (24%) |
| Not working |  |  |  |  |  |  | 12 | 12 (9 %) |
| Total | 64 | 15 | 05 | 05 | 16 | 08 | 19 | 132 |
| Percentages | 60% |  | 20% |  |  | 6% | 14% | 100% |

Table I5 reveals that the majority of BScN graduates (60%), at the time of this study were working in clinical nursing as staff nurses or critical care nurses in Pakistan and abroad. Twenty-six (20%) were employed in a teaching role such as clinical nurse teachers at AKUH or nursing instructors at AKU-SON and other schools of nursing in the country, whereas eight (6%) graduates were hired in a first-line management role such as head nurse, deputy director, and case manager. Of note, in 2006 one graduate from the first cohort who had completed her master's degree in epidemiology was hired as a principal at a school of nursing, which is the highest level of administrative position offered to any of the BScN graduates until 2006.

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[3] Fifteen in UK, 7 in North America, and 1 in Dubai.